VERMONT
Department of Financial Regulation

Insurance Division's

RULE H-2009-03
IMPLEMENTATION MANUAL

Consumer Protection & Quality Requirements
for
Managed Care Organizations

UPDATED: DECEMBER 2014

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INTRODUCTION

Rule H-2009-03 ("Rule 9-03"), Consumer Protection and Quality Requirements for Managed Care Organizations, was promulgated and took effect on December 17, 2009. Rule 9-03 seeks to ensure that each managed care organization (MCO) offered to consumers in Vermont provides quality health care to its members and complies with consumer protection requirements.

This manual is intended to provide guidance on how MCO performance will be assessed by the Department of Financial Regulation ("the Department"). The manual has five sections:

Section I: contains a description of the Department's Rule 9-03 compliance evaluation and performance assessment process.

Section II: contains a description of the Rule 9-03 compliance scoring procedures.

Section III: provides a summary of the requirements for the grievance process.

Section IV: contains the specific Rule 9-03 requirements and corresponding evaluation criteria for each.

Section V: contains Appendices, including a link to the July 15th data filing specifications, quality improvement goal template, provider contract regulatory addendum and standard DFR rights notices.

SECTION I: MCO COMPLIANCE EVALUATION ASSESSMENT PROCESS

MCOs are expected to satisfy a comprehensive set of Rule 9-03 requirements to ensure the effective delivery of accessible, responsive, quality health care to Vermont consumers. There are four primary activities in the Department's compliance evaluation and performance assessment process: A) formal Rule 9-03 compliance evaluations, B) annual reviews of MCO data filings, C) the annual quality improvement goal process, and D) focused reviews of specific topical areas, as needed. Each activity is described below.

A. Formal Evaluations of Rule 9-03 Compliance

The Department conducts three types of formal compliance evaluations: an initial baseline review, periodic (triennial) reviews, and reviews of material changes. Formal evaluations are focused on two goals:

- ensuring compliance with the requirements of Rule 9-03; and
- identifying and fostering opportunities for improvement in MCO performance relative to those requirements.

1. Baseline reviews

Baseline reviews are conducted by the Department, upon application or at any other time as determined, of a managed care organization for authorization to conduct business in Vermont. It is designed to ascertain the managed care organization's ability to comply with the requirements of Rule H-2009-03 and to ensure acceptable standards of quality for its members. The baseline review consists of Department review and approval of policy documents and other materials submitted to demonstrate compliance with Rule 9-03. The Department notifies the MCO in advance of the Rule 9-03 requirements that will be assessed as part of the baseline review.

Following an MCO's initial submission of materials and review completed by the Department, the Department provides the MCO with a preliminary report of its performance that identifies those Rule 9-03 requirements for which the MCO must provide additional documentation or more adequately

demonstrate compliance. The MCO is allowed a specific period of time, usually between thirty (30) and sixty (60) days, within which to submit additional documentation to achieve compliance with (i.e., "fully meet") specified requirements. The Department usually allows up to two corrective action periods of thirty (30) or sixty (60) days within which a MCO can achieve full compliance for specified Baseline Review requirements. The Department will then issue a final report. MCOs that fully meet the specified requirements of a Baseline Review, assuming all other required Vermont licensing requirements are met, may conduct business in Vermont subject to all applicable rules and regulations. The Department will then usually schedule a periodic (triennial) review once the MCO has at least six (6) months of operational experience in Vermont in order to evaluate compliance with the implementation and application of relevant policies and procedures.

2. Periodic (triennial) reviews

The periodic review is a comprehensive assessment of MCO compliance with Rule 9-03. Periodic reviews are conducted approximately every three years for those MCOs that have completed a baseline evaluation. They are similar to, but different in scope than, the baseline evaluation. The periodic review is conducted to not only ensure that appropriate policies and procedures have been adopted by MCOs, but also to test whether those policies and procedures have been properly implemented.

As with the baseline review, documentation of compliance with Rule 9-03 requirements is submitted by the MCO and assessed by the Department. In addition, the periodic review includes a review of MCO provider and member documents, such as provider credentialing records and member grievance files. Portions of this review may take place during a site visit to the MCO and potentially to MCO delegates.

The Department gives advance notice to MCOs of the Rule 9-03 requirements that will be the subject of the periodic review. If a site visit is to be conducted, each MCO submits their documentation in advance of the site visit for the Department's review. The site visit consists of a review of administrative and medical records and interviews with MCO personnel. In preparation for the review of MCO provider and member documents, the Department provides the MCO with a list of records and other documents that it will review. The periodic review can also include an assessment of information gathered from consumer and provider complaints, inquiries and surveys regarding their experiences with the MCO. Throughout the periodic review process, the Department is available to respond to MCO questions.

The Department issues MCO-specific preliminary reports following completion of desk reviews and site visits, consisting of assessments of MCO performance on each individual requirement and an aggregate numerical score(s). The MCO is allowed a period of time, usually between thirty (30) and sixty (60) days within which to comment and submit additional documentation for any unmet requirements in the preliminary report. The Department reviews any additional MCO materials or comments and may conduct a limited site visit to further assess compliance. After that review, the Department issues a final report. The final report will include a Plan of Correction should any requirements under review remain unmet.

The MCO will be given a period of time, up to 60-days, to implement the Plan of Correction. The Department reviews any additional MCO documentation or actions in response to the Plan of Correction to determine whether full compliance has been achieved. Additional limited site visits may also be necessary. If the MCO has not achieved full compliance after the Plan of Correction deadline, the Department may take enforcement action.

3. Review of material changes

On an annual basis, on or before July 15th, pursuant to Rule 9-03, Section 6.6(B) 16, MCOs are required to submit to the Department any material changes to policies, procedures, member communications, provider contracts or other documents required by the Rule. This submission must include a report on the status of delegated arrangements (additional information regarding the Department's evaluation of delegated MCO functions is found on pages 11 and 12 of this manual). The Department reviews such

submissions as they are received, and provides the MCOs with a compliance evaluation.

B. Annual Reviews

All MCOs subject to annual reviews must submit the data filings required under Section 6.6 of Rule 9-03 to the Department on or before July 15th of each year, with the exception of the annual Quality Improvement Work Plan (covering the current calendar year) that must be filed on March 31st of each year. Non-reporting of required measures is grounds for enforcement action.

To ensure the usefulness of the data filings, the Department requires standardized reporting by MCOs of key performance indicators that can be used to evaluate MCO performance and identify opportunities for improvement. The **Healthcare Effectiveness Data and Information Set** (HEDIS®) is one set of indicators that the Department uses to specify reporting requirements. The Department also requires that all MCOs (with the exception of managed mental health care organizations) annually administer and report the results of the **Consumer Assessment of Healthcare Providers and Systems** (CAHPS), a standardized, nationally employed survey to assess health plan member satisfaction. Rule 9-03 also requires MCOs to file certain **Vermont-specific measures**.

In most instances the Department provides electronic spreadsheets to the MCOs to ensure consistent and accurate data submissions. In a few cases, the format and content are simply specified, with no electronic spreadsheets required. The specific instructions regarding the data that must be filed and the format in which they must be filed, including a data filing check list, are provided in **Appendix A** to this manual.

Once the data have been submitted by the MCOs, the Department analyzes the data and produces a report that compares MCOs to their own prior performance, to each other and to external benchmarks, as available. External benchmark data are generally obtained from the NCQA Quality Compass. The analysis also identifies opportunities for improvement specific to each MCO.

As further specified in **Appendix A**, as part of the annual July filing, MCOs are required to provide a complete list of the functions that are delegated and identify the entity(ies) to which the functions have been delegated and sub-delegated.

Changes in delegated functions and/or relationships are considered to be 'material changes', as the term is utilized within Section 6.6(B)16 of Rule 9-03. Whenever an MCO initiates changes to delegated functions and/or relationships, the MCO must submit to the Department any contracts between the MCO and the delegate, contracts between the delegate and providers, member communications, provider communications, detailed implementation plans regarding any changes that impact members, and any other relevant information. Such submissions must be received by the Department at least 90 days in advance of the proposed implementation of the change in delegated functions and/or relationships.

C. Annual Quality Improvement Goal Process

There are two types of annual quality improvement goal processes. The first is described below as the "traditional quality improvement goal process." The second is described as the "alternative quality improvement goal process." MCOs must complete two consecutive years of compliance with the traditional annual improvement goal-setting process to qualify for the alternative goal process. MCOs that have been identified by the Department as demonstrating a continuing commitment to the development and implementation of robust clinical and service quality improvement goals may then choose to use either the traditional goal process or the alternative goal process.

N.B.: Beginning in 2014, the Department will deem quality improvement goals to meet the Rule requirements if the MCO participates with the Blueprint for Health. [D.Bennett memo, Deeming Opportunities for Quality Improvement Activities, April 22, 2014]

1. Traditional quality improvement goal process

The Department and the MCO jointly identify and negotiate quality improvement goals on an annual basis. Information that may contribute to the development of goals includes: 1) the MCO's performance on its annual data filing, 2) the Department's annual Data Filing Evaluation Report, and 3) the results of the most recently conducted periodic review. The Department/MCO quality improvement goal process is intended to be collaborative and is aimed at improving performance. The Department and MCO work together to negotiate and finalize goal language, quality improvement interventions and improvement targets. The process is intended to support the MCO's existing individual and joint clinical quality improvement activities (as required under Sections 6.3(D) and 6.4 of Rule 9-03).

The traditional improvement goal-setting process is designed to:

a. Support each MCO in transforming the results of formal reviews, annual reviews, and/or feedback from consumers, advocates and providers into annual measurable individual and joint quality improvement goals;

b. Support each MCO as it seeks to achieve these goals, through mechanisms such as facilitating joint quality improvement goals between multiple MCOs and scheduling mid-year and year-end progress report meetings;

c. Annually evaluate how well the MCO performed on its goals, based on an evaluation of the MCO's submissions and mid-year and year-end progress report presentations; and

d. Establish new goals with the MCO for the next year. The new goals may consist of a continuation of prior year goals and the initiation of new efforts.

MCOs are expected to develop goals on a calendar year schedule. MCOs should identify topics and draft initial goal statements, interventions, well-defined measures and improvement targets in October or November. This allows for discussion between the Department and the MCO in November and December, with final goal adoption targeted for no later than January 31st. MCOs are expected to present mid-year progress and year-end results for the quality improvement projects. Mid-year goal review meetings between the Department and the MCOs generally occur in June or July, with end-of-year meetings scheduled for December or January. The Department may establish a different goal schedule on a case-by-case basis, upon MCO request.

An example of how an MCO's performance on a particular Rule 9-03 requirement might be translated into a goal can be found in Appendix D.

Section 6.4(B) of Rule 9-03 outlines the criteria that the Department will use to evaluate each quality improvement goal:

- Whether the goals are of adequate breadth in terms of the number and degree of difficulty of the goal activities and interventions;
- Whether the managed care organization has made a good faith effort to achieve each goal; and
- Whether improvement has been achieved.

In assessing MCO performance, the Department also evaluates whether the MCO's interventions were of sufficient ***strength, specificity*** and ***quality*** to support the conclusion that they contributed to measurable improvements in performance. Interventions must not be so generic that they most likely would have been initiated, and the performance improvement obtained, in the absence of goals. The MCO must be able to demonstrate that the improvement cannot be attributable to chance or other unrelated factors. The MCO must be able to document that statistically significant improvement has been achieved, with statistical significance defined as $p < .05$.

In the course of the year, if a MCO determines that continued efforts toward the achievement of a particular goal are not warranted, the MCO must notify the Department. At the Department's discretion, an alternative goal may be proposed by the MCO and accepted by the Department. The Department does not make allowances, when assessing MCO performance, when an MCO fails to contact the Department to re-negotiate a goal and subsequently fails to meet the goal.

2. Alternative quality improvement goal process

The alternative quality improvement goal process is comprised of the following components:

a. The Department annually produces the Rule 9-03 Data Filing Evaluation Report and identifies those opportunities for improvement that most warrant MCO improvement activity. MCOs may use information from current or previous Data Filing Evaluation Reports, their own internal data, or recent periodic review reports to develop quality improvement goals.

b. The goals should include goal statements, interventions/activities, well-defined measures and improvement targets. The Department reviews the descriptions and makes recommendations.

c. Generally, the selection of quality improvement goal topics is at the discretion of the MCO participating in this abbreviated process. However, at its discretion, the Department may occasionally select topics for the MCO to pursue. Goals, objectives and measures should be quantifiable whenever feasible and appropriate.

d. MCOs are required to present year-end results of the quality improvement projects, including at least one joint mental health project between the MCO and its mental health delegate as required by Section 6.4(C) of Rule 9-03 (if applicable), and at least two joint goals with other MCO(s) as required by Section 6.3(D).

e. At the Department's discretion, an MCO that does not adequately meet the requirements of this alternative quality improvement goal process may be required to resume the traditional goal setting process during the subsequent year, including improvement goal negotiation, and mid-year and year-end progress report meetings on their QI goals.

D. Focused Reviews

Focused reviews may occur during the course of any year at the discretion of the Department. These reviews are detailed examinations of particular aspects of MCO performance. The focused topic reviews may include a review of documentation and/or site visits. Potential means for topic identification may include periodic review findings, the analysis of data submissions, and complaints received by the Department.

E. Publication of Results of Reviews

The Department, at its discretion, may publish the results of baseline, periodic and annual reviews. The Department may also produce a consumer guide that describes findings from the MCOs' annual data filings. Prior to publication, the Department will send MCOs the data used to calculate the consumer guide ratings for their review.

MCOs that wish to publicize results of the Department's baseline, periodic, annual or focused reviews, must obtain Department approval of all publicity or marketing materials before doing so.

SECTION II: COMPLIANCE SCORING PROCEDURES

A. Understanding the Scoring System

The Department has developed an evaluation tool for assessing compliance with Rule 9-03 requirements. This evaluation tool is provided in Section V of this manual. The Department uses the tool during each MCO's baseline and periodic reviews, and may use it during focused reviews. It is employed to assess the degree to which the MCO meets each requirement.

1. Three point scale

For some requirements (generally those in Part 6 of Rule 9-03), there is a three-point scoring system. This scoring system aids the Department in identifying when MCOs fail to meet a requirement, and in identifying areas of best practice when MCOs exceed a requirement.

The Rule 9-03 three-point scale is as follows:

1 = Does Not Meet Requirement
2 = Meets Requirement
3 = Exceeds Requirement

2. Pass-fail scale

Other requirements (generally those relating to consumer protections) are scored on a pass-fail basis. The pass-fail scale is as follows:

1 = Does Not Meet Requirement
2 = Meets Requirement

3. Assigning scores as part of a review

A "1" indicates that the MCO's submission failed to meet the requirement. A "2" indicates that the submission demonstrated full compliance with the requirement. A "3" indicates that the MCO exceeded the Rule 9-03 requirement consistent with the practice of superior MCOs. Identifying this higher level of performance is intended to serve the interests of Vermont consumers by motivating ongoing continuous quality improvement (CQI) activities among MCOs.

In order to score a "3" on a Rule 9-03 requirement, MCOs must generally demonstrate not only compliance with the Rule, but that they are continuously measuring their own effectiveness at achieving the requirement, acting upon their findings, and implementing mechanisms for improvement that result in demonstrable, quantifiable improvements.

4. Incorporation of site visit reviews

As mentioned earlier, some reviews entail site visits. These site visits may provide information on performance that serves to supplement information contained in previously submitted documents. They can also serve as the sole basis for performance assessment for specific Rule 9-03 requirements.

5. Evaluation of delegated MCO functions

When a review of an MCO includes an assessment of a delegated entity, the entity's performance is also reviewed for relevant Rule 9-03 requirements and factored into the total assessment of the MCO's performance. This is done as follows:

a. If the MCO entirely delegates the activity, the reviewer's assessment of the delegated entity's performance on the requirement comprises the entire MCO score for that requirement.

b. If both the MCO and the delegated entity share responsibility for the activity, then the performance of both the MCO and the delegated entity are factored into the assessment of the MCO's performance. For example, if the MCO is assessed to have met the requirement, but the delegated entity's performance failed to warrant an assessment that it met the requirement, then the score for that requirement, in most cases, will be that of the delegated entity's performance.

The Department is aware that MCOs sometimes delegate certain functions such as utilization review, grievance review, credentialing and contracting to one or more contracted providers, provider organizations (e.g., PHOs) or other contractors. In such cases, the "delegated entities" must also demonstrate to the Department that their performance is in compliance with the Rule 9-03 requirements relevant to those activities.

An MCO may demonstrate that its delegates meet Rule 9-03 requirements in one of two ways:

- First, the MCO may facilitate the Department's direct review of delegate policies, contracts and records relevant to Rule 9-03 requirements.
- Second, the MCO may document that it has conducted its own review of delegate compliance with all of the elements of Rule 9-03 that are under review, and report its findings.

If an MCO elects to pursue this second option, the MCO should employ a sampling methodology that calls for at least 10 randomly selected records to be reviewed for each assessed Rule 9-03 requirement. If an MCO elects the second option and the Department finds that the MCO's sampling methodology does not meet this guideline, the Department reserves the right to conduct direct reviews of delegate performance.

MCOs need not conduct oversight audits of delegates to determine Rule 9-03 compliance if the delegate is separately regulated under Rule 9-03 by the Department. However, MCOs must monitor the delegate's efforts to come into Rule 9-03 compliance when the Department has found that the delegate is not fully compliant.

If an MCO contracts with a PHO, which is acting on behalf of a group of subcontracted providers, the Department will interpret the PHO to have been delegated the provider contracting responsibility regulated by Rule 9-03, unless otherwise noted within the PHO-provider agreement. As such, the contracts held by the PHO and its subcontracted providers must comply with the relevant contract requirements specified by Section 5.3 of Rule 9-03.

6. NCQA and URAC accreditation deeming

The Department is aware that Vermont MCOs may undergo regular accreditation review by the National Committee for Quality Assurance (NCQA) or by URAC. To avoid unnecessary duplication of efforts by Vermont MCOs, the Department has compared Rule 9-03 requirements with current accreditation requirements of NCQA and URAC. In so doing, it has identified those Rule 9-03 requirements that have a direct parallel with those contained within NCQA and URAC standards. In the case of an MCO whose operations in Vermont have undergone NCQA review, the Department will allow the MCO to be deemed to "meet" an individual Rule 9-03 requirement (*i.e.*, receive a score of a "2") if it can demonstrate that it was judged to be in "full" compliance by receiving a score of 100% for the equivalent NCQA requirements in the MCO's most recent NCQA accreditation review of its service area that includes Vermont. In the case of an MCO whose operations in Vermont have undergone URAC review, the Department will allow the

MCO to be deemed to "meet" an individual Rule 9-03 requirement if the MCO's site that serves Vermont members has had a site visit, has achieved URAC Accreditation in its most current URAC accreditation review, and the URAC standards with which it must comply to achieve accreditation include a standard that is equivalent to the individual Rule 9-03 requirement being assessed.

a. Deeming in relation to delegated functions

The Department expects that each MCO delegate will comply with all applicable Rule 9-03 requirements. The Department is aware that accreditation organizations do not conduct focused compliance reviews with delegated organizations unless the delegates are themselves accredited. For this reason, the Department does not extend NCQA or URAC deeming to the performance of delegates unless the delegates have been independently accredited.

b. Accreditation standards used for deeming

The Rule 9-03 requirements in this version of the Implementation Manual were compared to the 2013 and 2014 NCQA Standards and Guidelines for the Accreditation of Health Plans and the URAC Health Utilization Management Accreditation Standards Version 7.0, and Pharmacy Benefit Management Accreditation; Version 2.0 The Department will reassess the comparison on a regular basis to ensure continued coordination with NCQA and URAC accreditation processes.

7. Plan of Correction scoring

Plan of Correction submissions from MCOs following the completion of final baseline review, periodic review, or focused review reports are scored using the pass-fail scale. Occasionally an MCO will demonstrate that preparations have been made and all processes are in place to meet a requirement but evidence of full implementation cannot yet be provided. In such cases where the MCO has taken specific steps to achieve compliance and made substantive progress toward implementing change, the MCO may be told that it has "conditionally met" the requirement, conditioned upon providing the necessary documentation after a planned and scheduled action has been implemented.

8. Calculating MCOs' aggregate scores

The Department may employ multiple means to summarize MCO performance on a given review. Two possible methods include the following:

a. calculating the percentage of assessed requirements for which the Department finds the MCO to be in compliance, and
b. calculating the mean of the MCO's individual scores for the assessed requirements.

B. Submitting Adequate Documentation

1. Vermont-specific responses

MCO documentation supporting Rule 9-03 compliance must demonstrate that the MCO's operations for Vermont members meet Rule 9-03 requirements. The documentation of operational practices in other states that have not been replicated for Vermont members shall be considered non-responsive.

2. Provision of record samples for Department review: INITIAL REVIEW

When the Department conducts a review of sampled cases, the following protocol will be used:

a. The MCO will be required to submit a listing of all cases that meet particular characteristics (e.g., first level grievances) for the time period chosen by the Department.
b. The Department will randomly select ten cases for review. In the event the MCO has fewer than ten cases that meet the selected characteristics, the Department will review all of the cases for the chosen time period.
c. In order to meet the requirement being reviewed, the MCO must demonstrate 90 percent compliance for the sample of cases.
d. In the event the MCO does not meet the 90 percent compliance threshold, a sample of 10 (or all cases in the event there are fewer than 10) will be reviewed for a new time period chosen by the Department.

3. Provision of record samples for Department review: SECONDARY REVIEW

a. In the event more than half of the original cases presented for review do not meet the specified characteristics, the Department will request an additional sample equal to the number of cases that do not meet the specified characteristics.
b. If after the second sample request, the denominator for the sample is less than 10, the Department will assess compliance with the available cases, and hence all sampled cases much meet the requirement to meet the 90% compliance threshold.
c. In the event some, but fewer than half, of the original sampled cases presented for review do not meet the selected characteristics, the Department will assess compliance based on those cases that do meet the selected characteristics and will not request additional cases to inform the Department's assessment of compliance.

4. Rule 9-03's applicability to managed mental health care organizations

To the extent that Rule 9-03 is applied by the Department to MCOs that limit their services to mental health and substance abuse services (known as managed mental health care organizations), all Rule 9-03 criteria are applied to those organizations, with the exception of those that are specific to non-mental health and substance abuse services (e.g., access to a primary care provider).

In addition, only certain HEDIS® indicators are required for the annual data filing. These are identified in Appendix A.

The CAHPS® survey is not required for managed mental health care organizations (MBHOs), however MBHOs are required to submit the Experience of Care Survey required under Act 129 for mental health and substance abuse services. This survey can be found in the Act 129 Data Filing Manual.

SECTION III: REQUIREMENTS FOR THE GRIEVANCE PROCESS

The Department has established the following guidelines to ensure uniformity and conformity with Rule 9-03 in grievance processes and definitions.

A. General Internal Requirements for the Grievance Process

1. Types of grievances

A grievance may pertain to the availability, quality or coverage of health care and administrative services. It may address denials of coverage (adverse benefit determinations), claims payments, MCO service, access to care, quality of care, or any other matter pertaining to the member's contractual relationship with the MCO. A grievance specifically pertaining to a member's request that the MCO reconsider a denial of coverage for a service may also be termed an "appeal." Grievances are categorized, for the purposes of Rule 9-03 reporting requirements, as follows:

a. grievances about pre-service denials requiring expedited review (called "Urgent Pre-Service Grievances");

b. grievances about pre-service denials not requiring expedited review (called "Non-Urgent Pre-Service Grievances");

c. grievances about post-service denials (called "Post-Service Grievances");

d. grievances about denials to continue or extend a course of treatment (called "Concurrent Review Grievances"); and

e. grievances related to the MCOs' services and contracted providers' care delivery (called "Grievances Unrelated to an Adverse Benefit Determination"), including:

1. grievances about a contracted provider's performance, including office staff, the condition of the office and its management, and competency (excluding grievances about access);
2. grievances about plan administrative performance, including overall coverage (such as certain services or certain medical supplies not being covered; member handbooks; membership card distribution; claims processing timeliness and accuracy; and member services); and
3. grievances about access to health care, including geographic and physical access, linguistic access, and time between when an appointment is requested and when it is scheduled.

2. First and voluntary second level grievances

MCO grievance processes cannot obligate members to go through an informal review of their grievance before the MCO staff will adhere to the Rule 9-03-prescribed processes and time lines for review of grievances. The "first-level review" is the MCO's initial response to a member's request for a grievance review.

SECTION IV: RULE H-2009-03 REQUIREMENTS AND EVALUATION CRITERIA

Introduction

Section IV of the Implementation Manual details requirements that could potentially be evaluated during periodic review and that MCOs must meet to be in compliance with Rule 9-03. The majority of the requirements, including all of those in Sections 1.5 through 6.2 and Sections 6.6 through 6.8, will be evaluated simply as either meeting or not meeting a requirement. For select requirements, including quality assurance, credentialing and chronic care requirements found in Sections 6.3 through 6.5, the Department provides criteria with which to assess whether an MCO has exceeded the Rule 9-03 standard.

The Department determines compliance in several different ways:

1. if compliance with the requirement can be measured quantitatively (e.g., the percentage of grievance reviews completed within a specified timeframe), the Department will find an MCO in compliance if it met the standard 90% of the time during the measurement period;

2. if compliance with the requirement cannot be measured quantitatively (e.g., "each managed care organization shall establish and implement policies, standards and procedures to protect the confidentiality…"), the Department will determine compliance through a review of written documentation; and

3. for a subset of requirements, the Department will determine compliance through a review of records, to be conducted either via an on-site audit, or through review of electronically communicated records. These record reviews are intended to confirm that MCO policies are being implemented as written and as required by Rule 9-03.

Where applicable, Section IV specifies when the Department will recognize achievement of NCQA or URAC accreditation as equivalent to compliance with a given Rule 9-03 requirement. References to the NCQA Standards and Guidelines for the Accreditation of Health Plans are cited within Section IV as "NCQA HP."

Rule H-2009-03		
	Quality Assurance Program Structure and Administrative Policies and Procedures	
1.3 (F)	If a managed care organization delegates any activities or functions to other persons or entities, the managed care organization may not delegate its responsibility for the activities or functions, is accountable for ensuring that its delegates operate in compliance with all applicable requirements and shall maintain effective oversight of those activities, which shall include:	
1.3 (F) 1	A written description of the delegate's activities and responsibilities, including reporting requirements;	
	1 = Does not meet	**2 = Meets**
1.3 (F) 2	Evidence of formal approval of the delegate's program by the managed care organization; and	
	1 = Does not meet	**2 = Meets**
1.3 (F) 3	A process by which the managed care organization at least annually evaluates the performance of the delegate and any sub-delegates, including but not limited to a process by which the managed care organization documents, tracks, addresses and resolves complaints from members and providers regarding the delegate's conduct and/or the conduct of any other managed care organization that performs any activities on its behalf.	
	1 = Does not meet	**2 = Meets**
1.5 1.5 (A)	Confidentiality of Quality Management and Peer Review Information Except as otherwise required by 18 V.S.A. § 9414, each managed care organization shall take the appropriate steps necessary to ensure that information gathered by it in its peer review and quality management activities, including those conducted in relation to credentialing, recredentialing and associated monitoring, shall be maintained as confidential and privileged. **Deeming Opportunity**: MCO fully meets URAC Health Plan Standards Version 7.0 P-CR-6, Credentialing Confidentiality.	
1.5 (C)	The minutes or records of the peer review or quality management committee formed under Parts 5 or 6 of this rule are confidential and privileged under 26 V.S.A. § 1443, except as otherwise provided in 18 V.S.A. § 9414(f)(2) and this rule.	
	1 = Does not meet	**2 = Meets**
2.1	Maintenance of Health Care Information; Confidentiality Procedures. Each managed care organization shall establish and implement policies, standards and procedures to protect the confidentiality, security and integrity of individually-identifiable health care information in its possession or used by it in order to ensure that the information is not negligently, inappropriately or unlawfully disclosed. For purposes of this section, "individually-identifiable health care information" means any data or information, whether oral or recorded, in any form or medium, that identifies an individual or can reasonably identify an individual by reference to publicly-available information; relates to the individual's health history, health care or health status; and is obtained by or from a health care provider, a health care facility, a health insurer, or an employer. These policies, standards and procedures shall include: **Deeming Opportunity:** MCO fully meets NCQA HP RR 5, Element A or fully meets URAC Case Management Standards Version 4.0 Core 16.	
	1 = Does not meet	**2 = Meets**

Rule H-2009-03		
	Quality Assurance Program Structure and Administrative Policies and Procedures	
2.1 (A)	the use of nondisclosure and confidentiality policies and agreements, which shall include guidelines for access to health care information on a need-to-know basis only, and safeguards to enforce those guidelines; **Deeming Opportunity:** MCO fully meets NCQA HP RR 5, Elements A, B, and F or fully meets URAC Case Management Standards Version 4.0 Core 16.	
	1 = Does not meet	**2 = Meets**
2.1 (B)	periodic training for all employees as to the policies, standards and procedures established under this provision, applicable state or federal laws or regulations as to the confidential handling of health care information, and any related licensing rules or professional ethical standards;	
	1 = Does not meet	**2 = Meets**
2.1 (C)	disciplinary measures for violations of the managed care organization's confidentiality policies, standards or procedures; **Deeming Opportunity:** MCO fully meets NCQA HP RR 5, Element F.	
	1 = Does not meet	**2 = Meets**
2.1 (D)	the identification of individuals who are authorized to disclose individually-identifiable health care information;	
	1 = Does not meet	**2 = Meets**
2.1 (E)	methods for handling, disclosing, storing and disposing of individually-identifiable health care information, including procedures for appropriate responses to court-ordered legal process, legal or regulatory process from a governmental entity or legal process issued by an attorney; and	
	1 = Does not meet	**2 = Meets**
2.1 (F)	if the managed care organization is an employer of or contracts with the individual whose information is being collected or used for health care services purposes, policies, standards and procedures to ensure that the individual's health care information is maintained separately and apart from the individual's other records and is used only for the lawful health care purposes for which the information was acquired.	
	1 = Does not meet	**2 = Meets**
2.2 2.2 (A)	Disclosure of Information Policy Forms, Certificates and Handbooks: Each managed care organization that issues, is the plan administrator for or is a delegate responsible for the plan documents specified below that relate to a comprehensive major medical health benefit plan subject to the Department's jurisdiction shall ensure that the policy form or certificate, and handbook if used, are approved by the Department prior to use and meet the following requirements in addition to any other requirements specified by the Department:	

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2.2 (A) 1.	The text shall be in at least eleven-point font in hard copy; in plain language at no greater than an eighth grade reading level, or less if required by other law; shall be organized in a way that is visually easy to read and use; and shall include a table of contents and a definitions section. The Department, in its sole discretion, may waive the eighth grade reading level requirement for parts of the text for good cause shown.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 2.	The documents shall be made available in hard copy, on the internet and in a format suitable for electronic mailing; provided to each member in the format requested upon enrollment and upon any changes thereafter; and shall also be made available upon request to prospective members prior to enrollment. A managed care organization may satisfy the requirements of this section by giving a copy of the approved policy form and the handbook, if used, to each subscriber rather than to each individual member. Information shall be provided to members regarding how to obtain necessary translation or interpretation of the document.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3.	At least the following information shall be contained in the policy form or certificate and, if a handbook is used, in the handbook: <u>Clarification</u>: *Handbooks may incorporate certificate content by reference, but because certificates are controlling legal documents, certificates may not incorporate handbook content by reference.*	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3. a	The health benefit plan's coverage provisions, including a clear description of the service area, if applicable, health care benefits, benefit maximums, benefit limitations, exclusions from coverage (including procedures deemed experimental or investigational by the managed care organization), restrictions on referral or treatment options, requirements for prior authorization, utilization review, notification of hospital admission or other member obligations to notify the managed care organization, the use of formularies, and any other limitations on the services covered under the member's enrollment plan. All plan materials, including a handbook if one is used, shall clearly explain the legal effect of each plan document. **Deeming Opportunity:** MCO fully meets NCQA HP RR 3 Element A and all plan materials, including a handbook if one is used, clearly explain the legal effect of each plan document.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3. b	If prior authorization or utilization review is required before obtaining treatment or services, the process a member must use to obtain that authorization or review, including any time lines that apply and how to obtain an expedited review. **Deeming Opportunity:** MCO fully meets NCQA HP RR 3, Element A.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3. c	The financial inducements offered to any health care provider or health care facility for the reduction or limitation of health care services. Nothing in this paragraph shall be construed to require disclosure of individual contracts or the specific details of any financial arrangement between a managed care organization and a health care provider unless otherwise required by law.	

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	1 = Does not meet	**2 = Meets**
2.2 (A) 3. d	The member's responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charges, annual limits on a member's financial responsibility, caps on payments for covered services, and the member's financial responsibility for non-covered procedures, treatments or services. **Deeming Opportunity:** MCO fully meets NCQA HP RR 3.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3. e	The member's financial responsibility for payment when services are provided by a health care provider who is not a contracted provider with the managed care organization, as applicable, or by any provider after an adverse benefit determination by the managed care organization.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3. f	A description of the grievance process used to resolve disputes between a member and the managed care organization, and how the member can access that process.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3. g	A summary of the managed care organization's quality management program.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3. h	An explanation that emergency services do not require prior authorization; that coverage for emergency services outside of the service area will be the same as for emergency services within the service area; that it is the responsibility of the managed care organization or health insurer to respond to, defend against and resolve any request or claim by a non-contracted provider of emergency services for payment exceeding the amount it was paid or reimbursed by the member's managed care organization or health insurer; and the point of contact at the managed care organization or health insurer for a member who receives any such request or claim.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3. i	How members seeking information or authorization can contact the appropriate department or staff member of the managed care organization.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3. j	How the member may obtain the most current provider directory and provider lists in a manner and format readily accessible to the member. **Deeming Opportunity:** MCO fully meets NCQA HP RR 3, Element A.	
	1 = Does not meet	**2 = Meets**

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2.2 (A) 3. k	The process for selecting primary care providers (if selection is encouraged or required) and for obtaining access to other providers under contract with the managed care organization, including any restrictions on the use of contracted specialists. **Deeming Opportunity:** MCO fully meets NCQA HP RR 3, Element A.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3. l	The procedure for changing primary and specialty care providers under contract with the managed care organization, including any restrictions on changing providers, where applicable.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3. m	How members can obtain standing referrals to contracted specialists, or use specialists or specialized facilities to provide and coordinate their primary and specialty care pursuant to the requirements of this rule, where applicable.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3. n	The waiting time and travel time standards established by this rule.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3. o	Opportunities for member participation in the development of managed care organization policies and in the managed care organization's quality management activities.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3. p	Information regarding consumer information and services, including local and toll-free consumer or member services telephone numbers for the managed care organization, the Department and the Vermont Office of Health Care Ombudsman, with an explanation of each organization’s respective role.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3. q	A list of all information available to the member upon request, as required by this rule.	
	1 = Does not meet	**2 = Meets**
2.2 (A) 3. r	If the managed care organization manages pharmaceutical benefits, the disclosure shall also explain in a clear and prominent manner that pharmaceutical benefit management with respect to particular drugs may change frequently; and how and where members and providers can access the primary source of up-to-date pharmaceutical benefit information, including but not limited to lists of the specific drugs subject to pharmaceutical benefit management; whether, how and under what conditions a particular drug is or is not covered by the plan; and the process by which grievances and exceptions to pharmaceutical benefit management decisions may be made.	
	1 = Does not meet	**2 = Meets**

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2.2 (B)	Provider Directories and Lists: Provider directories related to a comprehensive major medical health benefit plan subject to the Department's jurisdiction shall be made available to any member or prospective member upon request and shall meet the following requirements, as applicable: **Deeming Opportunity:** MCO fully meets NCQA HP RR 4.	
	1 = Does not meet	**2 = Meets**
2.2 (B) 1.	Provider directories shall be available on the Internet and made available upon request in hard copy and in a format suitable for electronic mailing. The provider directory may be separate from the policy form or handbook if the policy form or handbook clearly indicates how the member or prospective member can access the most up-to-date version of the directory. **Deeming Opportunity:** MCO fully meets NCQA HP RR 4 and makes directories available in hard copy and in a format suitable for electronic mailing upon request.	
	1 = Does not meet	**2 = Meets**
2.2 (B) 2.	Provider directories shall:	
2.2 (B) 2. a.	be updated, audited and corrected (by addendum or otherwise) at least once every six (6) months by the managed care organization, and shall be updated whenever new information is submitted by providers;	
	1 = Does not meet	**2 = Meets**
2.2 (B) 2. c.	include provider names, telephone numbers, and addresses; and in the case of physicians, include information about board certification; and **Deeming Opportunity:** MCO fully meets NCQA HP RR 4.	
	1 = Does not meet	**2 = Meets**
2.2 (B) 2. d.	in the case of primary care providers, indicate whether they are accepting new patients. **Deeming Opportunity:** MCO fully meets NCQA HP RR 5, Element A.	
	1 = Does not meet	**2 = Meets**
2.2 (B) 3.	Provider directories shall indicate at least the following practice limitations if reported by contracted providers: limitations as to patient age groups and specific conditions. This requirement shall not be construed to require indication of practice limitations that are evident based on a provider's specialty.	
	1 = Does not meet	**2 = Meets**

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2.2 (B) 4.	Provider directories shall explain that the member (and/or the member's representative) may obtain active assistance from the managed care organization to locate a provider, from a clinical representative if preferred and requested. For the purposes of this subsection, "active assistance" shall include but not be limited to generating a provider list; assisting members in identifying providers who are qualified to deliver the type of care being sought, who are currently taking new patients, and who provide services that are generally considered to be covered benefits; and facilitating appointments with providers if such assistance is required. Provider directories shall explain that the member should contact the managed care organization if the member has been unable to locate a provider using the list or with assistance previously provided.	
	1 = Does not meet	**2 = Meets**
2.2 (B) 5.	If a case or care management or chronic care program is available, the provider directory shall explain the benefits of participation and how the member may obtain the service or shall reference the plan documents that contain this information.	
	1 = Does not meet	**2 = Meets**
2.2 (B) 6.	Provider directories shall explain that coverage is not guaranteed until the requirements for utilization review have been completed and documentation of authorization has been issued. Such explanation shall include a description of or reference to certificate or handbook provisions that explain how to seek authorization; how to seek authorization if the member (and/or the member's representative) believes the necessary care is not available from contracted providers; how to initiate a grievance if coverage has been denied, reduced, modified or terminated; and the potential consequences if authorization is not obtained.	
	1 = Does not meet	**2 = Meets**
2.2 (B) 7. a	Provider directories shall also, with respect to mental health and substance abuse services: explain in a clear and prominent manner that a given provider's availability to new patients may change frequently;	
	1 = Does not meet	**2 = Meets**
2.2 (B) 7. b	clearly indicate when there are program, clinic or similar organizationally-based requirements that limit or prevent general plan membership from directly accessing a provider practicing in such a setting. In such cases, the directory shall list the program, clinic or organization name above or together with the individual provider's name, and shall list the relevant intake phone number and address. If the provider has a separate practice that may be accessed directly by general plan membership, that practice shall be listed separately;	
	1 = Does not meet	**2 = Meets**
2.2 (B) 7. c	explain that any provider of mental health or substance abuse services not currently under contract with the managed care organization that is willing to meet the terms and conditions for participation may apply for contracted status and may become contracted after successful completion of credentialing; and	
	1 = Does not meet	**2 = Meets**
2.2 (B) 7. d	in addition to being updated, audited and corrected whenever new information is submitted by providers, be updated based on current information from individual contracted providers that is obtained in response to active solicitation by the managed care organization at least once every six (6) months.	

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	1 = Does not meet	**2 = Meets**
2.2 (B) 8.	Provider lists shall contain the health care and geographic information requested by the member and be provided telephonically, in hard copy or in a format suitable for electronic mailing, whichever is requested by the member.	
	1 = Does not meet	**2 = Meets**
2.2 (C) 2.2 (C) 1.	Oral and Written Communications With Members Managed care organizations shall ensure that all communications in response to inquiries regarding access to and reimbursement for covered services explain to the member or person contacting the managed care organization on the member's behalf, unless clearly not applicable:	
2.2 (C) 1. a.	that coverage and the extent and level of coverage are governed by the plan documents and are not guaranteed until all requirements for utilization review and grievance, if relevant have been completed and documentation of authorization has been issued;	
	1 = Does not meet	**2 = Meets**
2.2 (C) 1. b.	how documentation of the authorization, including the extent and level of coverage, will be issued; and	
	1 = Does not meet	**2 = Meets**
2.2 (C) 1. c.	when applicable, that a member may be billed by a non-contracted provider(s) for any balance between the provider's charges and the amount paid by the health benefit plan. Whether or not in response to an inquiry, all communications to a member regarding payment or reimbursement for emergency services rendered by a non-contracted provider shall include clear notice that it is the responsibility of the managed care organization or health insurer to respond to, defend against and resolve any request or claim by a non-contracted provider of emergency services for payment exceeding the amount it was paid or reimbursed by the member's managed care organization or health insurer; and shall include information regarding the point of contact at the managed care organization or health insurer for a member who receives any such request or claim.	
	1 = Does not meet	**2 = Meets**
2.2 (C) 2.	Managed care organizations shall meet the following additional requirements with respect to communications regarding mental health and substance abuse services:	
	1 = Does not meet	**2 = Meets**
2.2 (C) 2. a.	The managed care organization shall explain that the member (and/or the member's representative) may obtain active assistance from the managed care organization, including from a clinical representative if preferred and requested, to locate a provider list that will assist them in identifying providers who are qualified to deliver the type of care being sought, are currently taking new patients, and provide services that are generally considered to be covered benefits;	
	1 = Does not meet	**2 = Meets**

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2.2 (C) 2. b.	the managed care organization shall explain that if a member wishes to access a provider of mental health or substance abuse services not currently under contract with the managed care organization, a provider willing to meet the terms and conditions for participation may apply for contracted status and may become a contracted provider after successful completion of credentialing;	
	1 = Does not meet	**2 = Meets**
2.2 (C) 2. c.	in the case of any inquiry or request for a provider list regarding a level of mental health or substance abuse care more intense than office-based outpatient services or that otherwise indicates an urgent, medically complex or unique situation related to mental health or substance abuse, the managed care organization shall transfer the member to a clinical representative of the managed care organization for assistance; and	
	1 = Does not meet	**2 = Meets**
2.2 (C) 2. d.	when a clinical representative response is required under paragraphs a, b, or c of this subsection, the representative shall offer assistance, as appropriate, to initiate utilization management and, if relevant, inform the person making the inquiry whether a relevant case management or chronic care program is available, the benefits of participation and how the member may obtain the service.	
	1 = Does not meet	**2 = Meets**
2.2 (C) 3.	The managed care organization shall maintain evidence of compliance with the requirements of this section for all of its communications with or on behalf of members. Failure to produce evidence of compliance shall result in a presumption favoring the member's position in the event of an internal grievance and any complaint to or enforcement action by the Department.	
	1 = Does not meet	**2 = Meets**
2.3 2.3 (A)	<u>Access To and Continuity of Care: Generally</u> Managed care organizations shall ensure that their policies and procedures facilitate the provision of health care services to their members in a manner informed by generally accepted medical or scientific evidence consistent with prevailing standards of medical practice as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition, and shall take into account the unique needs of each individual patient and each presenting situation.	
	1 = Does not meet	**2 = Meets**
2.3 (B)	Each managed care organization shall ensure timely access to effective, medically necessary care and shall monitor and take action, as necessary, to improve coordination and continuity of care for its members across service providers. For purposes of this section, "coordination and continuity of care" means that a member's health care services are managed by the managed care organization(s) in a manner that facilitates collaborative and effective treatment of a condition, illness or other medical condition, including but not limited to ensuring that the managed care organization: **Deeming Opportunity:** MCO fully meets NCQA HP QI 10, Element A <u>and</u> ensures timely access to effective, medically necessary care.	
	1 = Does not meet	**2 = Meets**

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2.3 (B) 1.	manages the benefits available for treatment of mental health and substance abuse conditions in a manner that allows for the effective provision of medically necessary care in urgent, medically complex, and unique situations, including but not limited to situations involving children and adolescents;	
	1 = Does not meet	**2 = Meets**
2.3 (B) 2.	has authorized covered benefits necessary for a medically safe and appropriate discharge or transition plan developed after consultation with the treating health care provider or the provider's designee before the managed care organization renders a decision that will result in discharge or transfer from a facility; and	
	1 = Does not meet	**2 = Meets**
2.3 (B) 3.	collaborates with health care providers to monitor and improve coordination between mental health and other health care.	
	1 = Does not meet	**2 = Meets**
2.4 2.4 (A)	Access To and Continuity of Care: Emergency and Urgent Services. Each managed care organization shall ensure that its members have access to emergency services twenty-four (24) hours per day, seven (7) days per week inside the health benefit plan's service area, and coverage for such services whether the member is inside or outside the health benefit plan's usual service area at the time such services are needed. **Deeming Opportunity:** MCO fully meets NCQA HP UM 12.	
	1 = Does not meet	**2 = Meets**
2.4 (B)	If a prudent layperson or provider would have believed that an emergency medical condition existed, a managed care organization shall cover emergency services provided in a hospital or other medically appropriate setting necessary to evaluate, stabilize and provide medically necessary emergency transport for a member. A managed care organization shall not require prior authorization of such services or the use of contracted providers. Coverage for the member shall be consistent with the terms and conditions for coverage of services obtained from a contracted provider within the service area whether or not the emergency services were obtained from contracted providers within or outside of the health benefit plan's service area. There shall be no additional liability to the member. The liability of a managed care organization or health insurer to a non-contracted provider for emergency services rendered to a member shall be limited to the reasonable and customary value for the health care services rendered, except that it shall be the responsibility of the managed care organization or health insurer to respond to, defend against and resolve any provider request or claim for payment exceeding the amount it paid or reimbursed the provider pursuant to this subsection.	
	1 = Does not meet	**2 = Meets**
2.4 (C)	A managed care plan shall cover emergency services if the managed care organization, acting through a contracted provider or through any other authorized representative, has authorized the provision of emergency services. In the event such authorization has been given or obtained, the managed care organization shall not subsequently retract its authorization after the emergency services have been provided, or reduce payment for an item or service furnished in reliance on the authorization, unless the authorization was based on a material misrepresentation about the member's health condition made by the member or by the provider of emergency services.	

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	1 = Does not meet	**2 = Meets**
2.4 (E)	Each managed care organization shall ensure that its members have access to urgently-needed care as defined in this rule inside the health benefit plan's service area, and coverage for such services whether the member is inside or outside the health benefit plan's usual service area at the time such services are needed. **Deeming Opportunity:** MCO fully meets NCQA HP QI 5, Element A and B.	
	1 = Does not meet	**2 = Meets**
2.5	Grievance Procedures for Managed Care Organizations Not Subject to Part 3. A managed care organization that does not use or administer utilization management mechanisms and that is therefore not subject to Part 3 of this rule shall have a review process available to address and resolve member grievances that meets the timeframes and other applicable requirements in Section 3.3 of this rule. **Deeming Opportunity:** MCO fully meets NCQA HP UM 8 and UM 9.	
	1 = Does not meet	**2 = Meets**
3.1 3.1 (A)	General Requirements for Utilization Management Programs. Each managed care organization shall be responsible for monitoring all utilization management activities carried out by it or on its behalf and for ensuring that all requirements of this rule and other applicable laws and rules are met. *Clarification: Compliance with the aspect of this requirement pertaining to monitoring of delegated entities shall be considered relative to requirement 1.3 (F).*	
	1 = Does not meet	**2 = Meets**
3.1 (B)	A managed care organization that conducts utilization management shall implement a written utilization management program that describes all utilization management activities, both delegated and non-delegated, for services provided to members. The program document shall describe, and, where applicable, the managed care organization shall ensure implementation of, the following: **Deeming Opportunity:** MCO fully meets NCQA HP UM 1 or is URAC-accredited for Utilization Management in URAC Health Plan Standards Version 7.0 P-HUM.	
	1 = Does not meet	**2 = Meets**

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3.1 (B) 1.	Procedures to evaluate whether the requested service is a covered benefit. In the case of new technology, services or treatment; or new application of existing technology, services or treatment, the managed care organization shall have a mechanism to evaluate its inclusion in the benefit package based on reviews of information from appropriate bodies, using professionals with appropriate specialty expertise in the new technology, services, or treatment and including consideration of determinations made by independent review organizations pursuant to 8 V.S.A. §4089 f; **Deeming Opportunity:** MCO fully meets NCQA HP UM 1 and UM 10 or is URAC-accredited for Utilization Management in URAC Health Plan Standards Version 7.0 –P-HUM-39 Independent External Review Process.	
	1 = Does not meet	**2 = Meets**
3.1 (B) 2.	procedures to evaluate the medical necessity, appropriateness, efficacy or efficiency of health services; **Deeming Opportunity:** MCO fully meets NCQA HP UM 1 and evaluates efficacy or efficiency of health services or is URAC-accredited for Utilization Management in URAC Health Plan Standards Version 7.0 P-HUM.	
	1 = Does not meet	**2 = Meets**
3.1 (B) 3.	the data sources and utilization review guidelines used in utilization management; **Deeming Opportunity:** MCO fully meets NCQA HP UM 1 or is URAC-accredited for Utilization Management in URAC Health Plan Standards Version 7.0 P-HUM.	
	1 = Does not meet	**2 = Meets**
3.1 (B) 4.	the process by which individual clinical case data, assessments and information are used together with utilization review guidelines during pre-service, concurrent and post-service reviews in making decisions to approve or deny requested health care services; **Deeming Opportunity:** MCO fully meets NCQA HP UM 2 and UM 6, or is URAC-accredited for Utilization Management in URAC Health Plan Standards Version 7.0 P-HUM.	
	1 = Does not meet	**2 = Meets**
3.1 (B) 5.	the process for conducting reviews of adverse determinations; **Deeming Opportunity:** MCO fully meets NCQA HP UM 4 Elements B, C and D, UM 7, UM 8, and UM 9 or is URAC- accredited for Utilization Management in URAC Health Plan Standards Version 7.0 P-HUM.	
	1 = Does not meet	**2 = Meets**

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3.1 (B) 6.	mechanisms to ensure the consistent application of utilization review guidelines and consistency in decisions such that, within the scope of coverage limits, decisions are compatible with the definition of "medically necessary care" in this rule and with the unique needs of each individual patient and each presenting situation. The mechanisms shall include annual training in utilization review guidelines and annual accuracy and interrater reliability testing for and with all reviewers; **Deeming Opportunity:** MCO fully meets NCQA HP UM 2, Element C or is URAC-accredited for Utilization Management in URAC Health Plan Standards Version 7.0 P-HUM; in addition to URAC or NCQA accreditation, the UM reliability mechanisms include annual training in utilization review guidelines and annual accuracy and interrater reliability testing for and with all reviewers.	
	1 = Does not meet	**2 = Meets**
3.1 (B) 7.	the data collection processes and analytical methods used in assessing the utilization of health care services by members;	
	1 = Does not meet	**2 = Meets**
3.1 (B) 8.	provisions for ensuring the confidentiality of clinical and proprietary information; **Deeming Opportunity:** MCO fully meets NCQA HP RR 5 or is URAC-accredited for Utilization Management in URAC Health Plan Standards Version 7.0 P-HUM.	
	1 = Does not meet	**2 = Meets**
3.1 (B) 9.	the organizational structure (for example, utilization management committee, quality management committee, or other committee) that periodically assesses utilization management activities and reports to the managed care organization's governing body; and **Deeming Opportunity:** MCO fully meets NCQA HP UM 1 or is URAC-accredited for Utilization Management in URAC Health Plan Standards Version 7.0 P-HUM.	
	1 = Does not meet	**2 = Meets**
3.1 (B) 10.	the staff position functionally responsible for the day-to-day management of the utilization management function. **Deeming Opportunity:** MCO fully meets NCQA HP UM 1 or is URAC-accredited for Utilization Management in URAC Health Plan Standards Version 7.0 P-HUM.	
	1 = Does not meet	**2 = Meets**

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3.1 (C)	Each managed care organization's utilization management program shall use documented utilization review guidelines that are informed by generally accepted medical and scientific evidence and consistent with clinical practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition. The managed care organization shall demonstrate to the satisfaction of the Commissioner that the utilization review guidelines have been periodically reviewed and updated, taking into account input from practicing physicians and other health care providers, including providers under contract with the managed care organization, if any. Relevant utilization review guidelines shall be made available to all providers under contract with the managed care organization, if any, and shall be made available to members and any of their treating providers upon request. **Deeming Opportunity:** MCO fully meets NCQA HP UM 2 and shall make utilization guidelines available to members and any of their non-contracted treating providers upon request or MCO is URAC-accredited for Utilization Management in URAC Health Plan Standards Version 7.0 P-HUM, and UR guidelines are made available to contracted providers, and to members and any of their non-contracted treating providers upon request.	
	1 = Does not meet	**2 = Meets**
3.1 (D)	Utilization management mechanisms shall:	
3.1 (D) 1.	not deter timely access to or compromise the effectiveness of medically necessary care for any condition;	
	1 = Does not meet	**2 = Meets**
3.1 (D) 2.	not result in any compromise to a member's safety;	
	1 = Does not meet	**2 = Meets**
3.1 (D) 3.	be of a nature, frequency and periodicity that is clinically reasonable in view of the diagnosis or condition generally, the nature of the service(s) under review and, with respect to concurrent review or other review during an ongoing course of treatment, that takes into account the member's past history, current condition and progress during the course of treatment; and	
	1 = Does not meet	**2 = Meets**
3.1 (D) 4.	take into account and make reasonable accommodations when a member's condition impacts the member's ability to follow utilization management procedures.	
	1 = Does not meet	**2 = Meets**
3.1 (E)	In addition to the other requirements in this part, utilization management mechanisms applied to mental health and/or substance abuse benefits shall:	
3.1 (E) 1.	be prospective or concurrent with the treatment unless otherwise requested by a member or his/her representative, or by a provider on behalf of a member;	
	1 = Does not meet	**2 = Meets**

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3.1 (E) 2.	not result in an adverse benefit determination until the reviewer has directly communicated with the member's treating mental health provider or the treating mental health provider's designee, unless the treating provider or designee has refused or repeatedly failed to engage in such communication when it has been offered at a time and in a manner reasonably convenient to the provider; <u>Clarification:</u> *This requirement applies to adverse benefit determinations regardless of whether they are concurrent, pre-service or post-service.*	
	1 = Does not meet	**2 = Meets**
3.1 (E) 3.	ensure that any adverse benefit determination shall include the evaluation, findings, and concurrence of a Vermont-licensed mental health professional whose training and expertise is at least comparable to that of the treating provider;	
	1 = Does not meet	**2 = Meets**
3.1 (E) 4.	be designed to allow a member to initiate a course of outpatient mental health or substance abuse treatment by directly accessing a contracted provider for a minimum of two visits without the member being required to initiate utilization management or provide notice to the managed care organization;	
	1 = Does not meet	**2 = Meets**
3.1 (E) 5.	be based on the complexity of the individual case and shall not require greater burden to the member or the treating health care provider than would be required for utilization management of similar benefits, including but not limited to requiring additional steps on the part of the member or provider, or requiring a greater investment of time by the member or provider in fulfilling requirements for utilization management; and	
	1 = Does not meet	**2 = Meets**
3.1 (E) 6.	take into account and be tailored to at least the following factors: the patient's clinical acuity; intoxication and/or withdrawal potential; biomedical, mental health and/or substance abuse co-morbidities; functional status; relapse potential; treatment and recovery history; and assessment of coping skills in view of the anticipated recovery environment.	
	1 = Does not meet	**2 = Meets**
3.1 (F)	Each managed care organization shall have a registered nurse or physician and, for mental health and substance abuse utilization management, a qualified licensed mental health care provider readily available by telephone seven (7) days a week, twenty-four (24) hours each day, to render utilization review determinations to members and treating providers.	
	1 = Does not meet	**2 = Meets**
3.1 (G) 3.1 (G) 1.	With regard to utilization management determinations, each managed care organization shall ensure that: Individual clinical case assessments and clinical data reported by the treating provider are given equal or greater weight than utilization review guidelines in making decisions to approve or deny care, with the former taking precedence over the latter when there is a conflict between the two. **Deeming Opportunity:** MCO fully meets NCQA HP UM 2.	

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	Quality Assurance Program Structure and Administrative Policies and Procedures	
	1 = Does not meet	**2 = Meets**
3.1 (G) 2.	All determinations to deny, limit, reduce, terminate or modify an admission, service, procedure or extension of stay are rendered by a physician under the direction of the medical director responsible for medical services provided to the managed care organization's members, except when the denial is based on eligibility for coverage or is a denial of a service that is clearly excluded from coverage and that could not in any way be considered an appealable decision pursuant to 8 V.S.A. §4089f or any other Vermont laws or rules regarding independent external review. **Deeming Opportunity:** MCO fully meets NCQA HP UM 2 Elements B and C, and UM 4, Elements A through E.	
	1 = Does not meet	**2 = Meets**
3.1 (G) 3.	If services that require prior authorization have been authorized and the services are either currently being provided to a member in a health care facility or are another type of ongoing course of treatment and the treating provider has determined that it is medically necessary for the ongoing course of treatment to continue without disruption or delay, the services shall continue to be covered until:	
3.1 (G) 3. a	the exhaustion of all internal expedited grievances, if requested within twenty-four (24) hours of receipt of the denial(s); or until the independent external review decision is issued, if expedited independent external review is requested within twenty-four (24) hours of the receipt of the final grievance decision and notice of appeal[1] rights by the member and is conducted in accordance with the time frames specified by law; and	
	1 = Does not meet	**2 = Meets**
3.1 (G) 3. b	the managed care organization has authorized coverage for a medically safe and appropriate discharge or transition plan developed after consultation with the member's treating health care provider or the treating health care provider's designee. For purposes of this subsection, a treating health care provider may select a hospital discharge planner as his or her designee.	
	1 = Does not meet	**2 = Meets**
3.1 (G) 4.	If the denial is upheld by an independent external review conducted pursuant to Vermont law, the managed care organization is not responsible for payment for the services that were the subject to the independent external review beyond the date the independent external review decision is issued. If the member nonetheless elects to continue the current level of treatment, the managed care organization may require that the member or treating provider contact the managed care organization in advance of discharge for the purpose of initiating utilization management regarding the discharge plan described in Subsection 3.1 (G) 3.b. above.	
	1 = Does not meet	**2 = Meets**
3.1 (G) 5.	Except in cases where there was material misrepresentation or fraud, the managed care organization shall not retroactively deny or limit reimbursement for the services described below. Nothing in this subsection prohibits managed care organizations from requiring utilization management mechanisms permitted by law or from communicating those requirements to members.	

[1] An appeal is a grievance made by a member to the MCO for reconsideration of the MCO's decision regarding the denial of a member's or provider's request for reimbursement for, or coverage of, a service that is not, or was not, believed by the MCO to be medically necessary at the time of the request and/or, is not covered under other terms of the member agreement.

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3.1 (G) 5. a.	A covered service the managed care organization determines, either upon receipt of the claim or upon grievance review, to have been medically necessary but the member failed to fulfill the member's obligation to obtain prior authorization. If the managed care organization chooses to issue an initial administrative denial when a member fails to obtain prior authorization, it shall also provide the member with clear notice that coverage will be provided if the managed care organization finds the service to be covered and medically necessary during grievance review. This subsection does not apply to a provider's obligation. Nothing in this subsection shall be construed to relieve a contracted provider from its obligation to comply with the managed care organization's utilization management mechanisms or to relieve a contracted provider of the consequences for failure to comply with such mechanisms;	
	1 = Does not meet	**2 = Meets**
3.1 (G) 5. b.	any covered service provided to an eligible member by a provider who relied upon the written or oral authorization of the managed care organization or its agents prior to providing the service to the member; or	
	1 = Does not meet	**2 = Meets**
3.1 (G) 5. c.	a covered service provided to a member by his or her primary care provider or another contracted provider who relied upon the written or oral referral of the primary care provider when the health benefit plan requires primary care physician referrals for members to use specialists.	
	1 = Does not meet	**2 = Meets**
3.1 (H)	Each managed care organization shall routinely assess the clinical and cost outcomes of its utilization management program, measure provider satisfaction with the utilization management program, and identify opportunities to improve provider satisfaction with the utilization management program. **Deeming Opportunity:** MCO fully meets NCQA HP UM 1, Element D and routinely assesses the cost outcomes of its utilization management program, measures provider satisfaction with the utilization management program, and identifies opportunities to improve provider satisfaction with the utilization management program.	
	1 = Does not meet	**2 = Meets**
3.1 (I)	Each managed care organization shall have a data system sufficient to support utilization management program activities, to generate management reports to enable it to effectively monitor and manage health care services provided to its members, and sufficient to meet the filing requirements of this rule.	
	1 = Does not meet	**2 = Meets**
3.1 (J)	Each managed care organization shall coordinate the utilization management program with its other medical management activities, including quality management, credentialing verification, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction, and risk management.	
	1 = Does not meet	**2 = Meets**

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3.1 (K)	Each managed care organization shall provide members and providers with access to its review staff by a toll-free number or such other secure mechanism with the goal of facilitating transmission of the information necessary for utilization review during a single, initial contact. Evidence that managed care organization reviewers are not promptly available when a provider or member initiates or schedules a required utilization review contact, that members or providers are required to initiate repeated telephone calls or voice mail transfers or are being required to submit duplicates of or redundant documentation, or similar evidence of repeated failure to facilitate reasonable utilization review practices may be considered a violation of this rule. **Deeming Opportunity:** MCO fully meets NCQA HP UM 3 and provides documentation that managed care reviewers are promptly available when a provider or member initiates or schedules a required utilization review contact, that members or providers are not required to initiate repeated telephone calls or voice mail transfers, and that members or providers are not required to submit duplicates of or redundant documentation or MCO is URAC-accredited for Utilization Management in URAC Health Plan Standards Version 7.0 P-HUM-2 and provides documentation that managed care reviewers are promptly available when a provider or member initiates or schedules a required utilization review contact, that members or providers are not required to initiate repeated telephone calls or voice mail transfers, and that members or providers are not required to submit duplicates of or redundant documentation.	
	1 = Does not meet	**2 = Meets**
3.1 (L)	When conducting utilization review, the managed care organization shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency and duration of services, including, for mental health and substance abuse services, information on the factors described in Section 3.1(E) 6 of this rule. **Deeming Opportunity:** the MCO is URAC-accredited for Utilization Management in URAC Health Plan Standards Version 7.0 P-HUM.	
	1 = Does not meet	**2 = Meets**
3.1 (M)	Compensation to persons providing utilization review services for a managed care organization shall not contain incentives, direct or indirect, for those persons to limit access to medically necessary care. Compensation to such persons may not be based, directly or indirectly, on the quantity or type of adverse determinations rendered. **Deeming Opportunity:** MCO fully meets NCQA HP UM 4, Element F.	
	1 = Does not meet	**2 = Meets**

Rule H-2009-03		
	Quality Assurance Program Structure and Administrative Policies and Procedures	
3.2 (A)	Utilization Review Procedures. Each managed care organization shall maintain written procedures for making utilization review decisions and for notifying members, representatives of members, and providers acting on behalf of members of its decisions consistent with the requirements of this rule. For purposes of this Part, the term "member" shall include an authorized representative of the member.	
3.2 (B)	For purposes of this section, the following reviews shall be treated as urgent: *Clarification: Consistent with the amended interim final regulations for claims and grievances processes in the Patient Protection and Affordable Care Act (ACA) published in the Federal Register on June 24, 2011 (http://webapps.dol.gov/federalregister/PdfDisplay.aspx?DocId=25131), after July 1, 2011* ***all*** *urgent pre-service review requests must be decided as soon as possible consistent with the medical exigencies of the case, but not later than seventy-two hours (72) hours after receipt of the request.* *A "claim involving urgent care" [29 C.F.R. § 2560.503-1(m)(1)] is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations — (A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, (B) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.*	
3.2 (B) 1.	all pre-service requests related to mental health and substance abuse conditions, unless the member or treating provider informs the managed care organization that the request is not urgent;	
	1 = Does not meet	**2 = Meets**
3.2 (B) 2.	all pre-service pharmacy benefit determinations, unless the member or treating provider informs the managed care organization that the request is not urgent;	
3.2 (B) 3.	all pre-service requests related to whether use of a prescription drug for the treatment of cancer is medically necessary or is an experimental or investigational use; and	
	1 = Does not meet	**2 = Meets**
3.2 (B) 4.	all requests designated as urgent by a member's health care provider or by the member.	
	1 = Does not meet	**2 = Meets**

Rule H-2009-03		
	Quality Assurance Program Structure and Administrative Policies and Procedures	
3.2 (C) 3.2 (C) 1.	Concurrent Review - Timeframe for Completion and Notification: If an ongoing course of treatment has been approved, a decision by a managed care organization to deny, limit, reduce, modify or terminate coverage or payment for such course of treatment, or to deny a request by or on behalf of a member to extend the course of treatment, in whole or in part, shall constitute an adverse benefit determination. *Clarification: Consistent with the amended interim regulations in the Patient Protection and Affordable Care Act (ACA), a request by a member or provider is considered an urgent concurrent care request if it meets the following criteria: (1) extends a course of treatment beyond the previously approved time period or number of treatments; (2) involves care that meets the definition of urgent care; and (3) is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.*	
	1 = Does not meet	**2 = Meets**
3.2 (C) 2.	A request to continue or extend a facility stay or other ongoing course of treatment as described in subsection 3.1(G) 3 of this Rule shall be decided as soon as possible consistent with the medical exigencies of the case. A managed care organization shall notify the member and treating provider (if known) in accordance with paragraph (G) of this section of the managed care organization's benefit determination (whether adverse or not) as soon as possible consistent with the medical exigencies of the case, but not later than twenty-four (24) hours after receipt of the request. *Clarification: Consistent with the amended interim regulations in the Patient Protection and Affordable Care Act (ACA), the managed care organization shall notify the member and treating provider (if known) not later than twenty-four (24) hours after receipt of the request only if the treatment is urgently needed and the request is made to the MCO at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.* **Deeming Opportunity:** MCO fully meets NCQA HP UM 5 or MCO is URAC-accredited for Utilization Management under URAC Health Plan Standards Version 7.0 or fully meets URAC Health Plan Utilization Standards Version 7.0 HUM 19 – Concurrent review time frames.	
	1 = Does not meet	**2 = Meets**
3.2 (C) 3.	In the case of an adverse concurrent review benefit determination regarding a facility stay or other ongoing course of treatment as described in subsection 3.1(G)3 of this Rule, when the grievance is requested and conducted consistent with the requirements of Section 3.1(G)3 of this Rule, neither the member nor the provider shall be liable for any services provided before notification to the member of the adverse benefit determination and the final outcome of any grievance or independent external review, unless the treating provider or designee has refused or repeatedly failed to engage in communication with the managed care organization when it has been offered at a time in a manner reasonably convenient for the provider, in which case the provider and not the member shall be liable for any services provided.	
	1 = Does not meet	**2 = Meets**

Rule H-2009-03		
	Quality Assurance Program Structure and Administrative Policies and Procedures	
3.2 (C) 4.	The managed care organization shall notify the treating provider and member of the determination orally as soon as the determination has been made. Written (either hard copy, or, if elected by the member or treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider and the member within twenty-four (24) hours of the oral notification. *Clarification: Consistent with the amended interim regulations in the Patient Protection and Affordable Care Act (ACA), the managed care organization shall notify the member and treating provider (if known) of the determination orally as soon as the determination has been made and in writing within 24 hours of oral determination only if the treatment is urgently needed and the request is made to the MCO at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.* **Deeming Opportunity:** MCO fully meets NCQA HP UM 5 or MCO is URAC-accredited for Utilization Management under URAC Health Plan Standards Version 7.0.	
	1 = Does not meet	**2 = Meets**

Rule H-2009-03		
	Quality Assurance Program Structure and Administrative Policies and Procedures	
3.2 (D) 3.2 (D) 1.	Urgent, Pre-Service Review - Timeframe for Completion and Notification[2]: For urgent pre-service review determinations, a managed care organization shall notify the member and treating provider (if known) of the managed care organization's benefit determination (whether adverse or not) as soon as possible consistent with the medical exigencies of the case, but not later than forty-eight (48) hours after receipt of the request. *Clarification:* Weekends and holidays, both legal and non-legal, are not exempt from the 48-hour time frame. *Additionally, a health plan, managed care organization, or mental health review agent must acknowledge receipt of both urgent and non-urgent prior authorization requests within 24 hours if it has not already responded to a completed prior authorization request or requested additional information within 24 hours of receipt.* *A "completed prior authorization request" is one that contains sufficient information such that a managed care organization is able to make a determination without requesting additional information.* *"Acknowledge" means to notify a health care provider of or make available to a health care provider a written receipt of the prior authorization request, through email, fax, or any other written means that can be accomplished within 24 hours. This is separate from the oral and written determination notice requirements contained in Rule H-2009-03.* *If a health plan, managed care organization, or mental health review agent does not respond to a completed prior authorization request, acknowledge receipt of a request for prior authorization, or request missing information within the required time frame, the prior authorization request is deemed to have been granted. If the managed care organization fails to act on a timely basis according to the statutory timeframe requirements for a prior authorization request, and the request is deemed to have been granted, the health plan, managed care organization or mental health review agent cannot recoup benefits/payments even if the requested treatment or service(s) are determined to be non-medically necessary.*	
	1 = Does not meet	**2 = Meets**

[2] Rule H-2009-03 requirement language has been modified to reflect the content Section 5a of Act 79 of 2013 and 18 V.S.A. § 9418b.

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3.2 (D) 2.	This period may be extended by not less than forty-eight (48) hours by the managed care organization if such extension is necessary due to a failure of the member or provider to submit the information necessary to decide the request. Oral and written notification of the need for additional information shall be provided to the member and the treating provider (if known) as soon as possible, but not later than twenty-four (24) hours after receipt of the request. <u>Clarification:</u> *The word "may" does not mean that the MCO may unilaterally decide to never extend review timeframes to obtain necessary information to decide a UR request. Rather, the MCO has the ability to decide whether such an extension is necessary on a per-case basis. As a result, an extension process policy and procedure description must be contained within the MCO's policy and procedures.* **Deeming Opportunity:** MCO fully meets NCQA HP UM 5, Element A and Element C.	
	1 = Does not meet	**2 = Meets**
3.2 (D) 3.	The managed care organization shall notify the treating provider (if known) and member of the determination orally as soon as the determination has been made. Written (either hard copy, or if elected by the member or treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider (if known) and the member within twenty-four (24) hours of the oral notification. **Deeming Opportunity:** MCO fully meets NCQA HP UM 5.	
	1 = Does not meet	**2 = Meets**
3.2 (E) 3.2 (E) 1.	<u>Non-Urgent, Pre-Service Review - Timeframe for Completion and Notification[3]:</u> For non-urgent, pre-service review determinations, a managed care organization shall notify the member and treating provider (if known) in accordance with paragraph (G) of this section of the managed care organization's benefit determination (whether adverse or not) as soon as possible consistent with the medical exigencies of the case, but not later than two (2) business days of receipt of the request. Written (either hard copy or, if elected by the member or treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider (if known) and the member. <u>Clarification:</u> *Weekends and legal holidays do not count as business days. Non-urgent requests received after normal business hours are deemed to have been received on the next business day.* *A "completed prior authorization request" is one that contains sufficient information such that a managed care organization is able to make a determination without requesting additional information.* *"Acknowledge" means to notify a health care provider of or make available to a health care provider a written receipt of the prior authorization request, through email, fax, or any other written means that can be accomplished within 24 hours. This is separate from*	

[3] Rule H-2009-03 requirement language has been modified to reflect the content of Section 5a of Act 79 of 2013 and 18 V.S.A. § 9418b.

<table>
<tr><th colspan="3">Rule H-2009-03</th></tr>
<tr><td></td><td colspan="2">Quality Assurance Program Structure and Administrative Policies and Procedures</td></tr>
<tr><td></td><td colspan="2">the oral and written determination notice requirements contained in Rule H-2009-03.

If a health plan, managed care organization, or mental health review agent does not respond to a completed prior authorization request, acknowledge receipt of a request for prior authorization, or request missing information within the required time frame, the prior authorization request is deemed to have been granted. If the managed care organization fails to act on a timely basis according to the statutory timeframe requirements for a prior authorization request, and the request is deemed to have been granted, the health plan, managed care organization or mental health review agent cannot recoup benefits/payments even if the requested treatment or service(s) are determined to be non-medically necessary.</td></tr>
<tr><td></td><td>1 = Does not meet</td><td>2 = Meets</td></tr>
<tr><td>3.2 (E) 2.</td><td colspan="2">This period may be extended one time by the managed care organization for up to fifteen (15) calendar days, provided that the managed care organization both determines that such an extension is necessary due to matters beyond its control and notifies the treating provider (if known) and member prior to the expiration of the initial fifteen (15) calendar day period, of the circumstances requiring the extension of time and the date by which the managed care organization expects to render a decision. If such an extension is necessary due to a failure of the member or treating provider to submit the information necessary to decide the request, the notice of extension shall specifically describe the required information, and the member or treating provider shall be afforded at least forty-five (45) calendar days from receipt of the notice within which to provide the specified information.

<u>Clarification:</u> The word “may” does not mean that the MCOs may unilaterally decide to never extend review timeframes to obtain necessary information to decide a UR request. Rather, the MCO has the ability to decide whether such an extension is necessary on a per-case basis. As a result, an extension process policy and procedure description must be contained within the MCO’s policy and procedures.

Deeming Opportunity: MCO fully meets NCQA HP UM 5, Element A and Element C <u>and</u> the MCO must provide that if an extension is necessary due to a failure of the member or treating provider to submit the information necessary to decide the request, the notice of extension shall specifically describe the required information, and the member or treating provider shall be afforded at least forty-five (45) calendar days from receipt of the notice within which to provide the specified information.</td></tr>
<tr><td></td><td>1 = Does not meet</td><td>2 = Meets</td></tr>
<tr><td>3.2 (F)
3.2 (F) 1.</td><td colspan="2"><u>Post-Service Review - Timeframe for Completion and Notification:</u>
For post-service review determinations, a managed care organization shall notify the member and treating provider (if known), in accordance with paragraph (G) of this section, of the managed care organization’s benefit determination (whether adverse or not) within a reasonable period of time, but not later than thirty (30) calendar days after receipt of the request. Written (either hard copy or, if elected by the member or treating provider, appropriately secure electronic) confirmation of the benefit determination shall be sent to the treating provider (if known) and the member.

Deeming Opportunity: MCO fully meets NCQA HP UM 5 and meets the requirements of Section 3.2(G) of this Rule.</td></tr>
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	1 = Does not meet	**2 = Meets**
3.2 (F) 2.	This period may be extended one time by the managed care organization for up to fifteen (15) calendar days, provided that the managed care organization both determines that such an extension is necessary due to matters beyond its control and notifies the member and treating provider (if known), prior to the expiration of the initial thirty (30) calendar day period, of the circumstances requiring the extension of time and the date by which the managed care organization expects to render a decision. If such an extension is necessary due to a failure of the member or treating provider to submit the information necessary to decide the request, the notice of extension shall specifically describe the required information, and the member or treating provider shall be afforded at least forty-five (45) calendar days from receipt of the notice within which to provide the specified information. <u>Clarification:</u> *The word "may" does not mean that the MCOs may unilaterally decide to never extend review timeframes to obtain necessary information to decide a UR request. Rather, the MCO has the ability to decide whether such an extension is necessary on a per-case basis. As a result, an extension process policy and procedure description must be contained within the MCO's policy and procedures.* **Deeming Opportunity:** MCO fully meets NCQA HP UM 5, Element A and Element C <u>or</u> MCO is URAC-accredited for Utilization Management in Health Plan Standards Version 7.0 P-HUM; <u>in addition</u> to NCQA or URAC accreditation, the MCO must provide that if an extension is necessary due to a failure of the member or treating provider to submit the information necessary to decide the request, the notice of extension shall specifically describe the required information, and the member or treating provider shall be afforded at least forty-five (45) calendar days from receipt of the notice within which to provide the specified information.	
	1 = Does not meet	**2 = Meets**
3.2 (G)	<u>Contents of Notice of Benefit Determination:</u> A written or electronic notification of a benefit determination shall set forth the following information in a manner calculated to be understood by the member:	
3.2 (G) 1.	a statement of the reviewer's understanding of the request;	
	1 = Does not meet	**2 = Meets**
3.2 (G) 2.	if applicable, a description of any additional material or information necessary for the member to perfect the request and an explanation of why such material or information is necessary;	
	1 = Does not meet	**2 = Meets**
3.2 (G) 3.	if the review resulted in authorization, a clear and complete description of the service(s) that were authorized and all applicable limitations or conditions;	
	1 = Does not meet	**2 = Meets**

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3.2 (G) 4.	if the review resulted in an adverse benefit determination, in whole or in part: a. the specific reason or reasons for the adverse benefit determination; b. the text of the specific health benefit plan provisions on which the determination is based; c. if the adverse benefit determination is based on medical necessity, an experimental/investigational exclusion, is otherwise an appealable decision pursuant to Vermont's independent external review laws, or is otherwise a medically-based determination, an explanation of the scientific or clinical judgment for the determination, and an explanation of how the clinical review criteria and the terms of the health benefit plan apply to the member's medical circumstance; d. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to the member upon request and free of charge within two (2) business days or, in the case of a concurrent or urgent pre-service review, immediately upon request; e. if the review is a concurrent or pre-service review, what, if any, alternative covered benefit(s) the managed care organization would consider to be medically necessary and would authorize if requested; f. a description of the managed care organization's grievance procedures and the time limits applicable to such procedures; g. in the case of a concurrent review determination or an urgent, pre-service request, a description of the expedited grievance review process that may be applicable to such requests; h. a description of the requirements and timeframes for filing grievances and/or a request for independent external review in order for the member or provider to be held harmless pending the outcome, where applicable; i. notice of the right to request independent external review after a grievance determination, in the language, format and manner prescribed by the Department; and j. local and toll-free numbers for the Department's health care consumer assistance section and the Vermont Office of Health Care Ombudsman. <u>Clarification:</u> *It is recommended that MCOs use the standard rights notices that have been developed by the Department for use in tandem with initial denial letters and grievance notices. If an MCO includes this template with all UR and grievance denial letters, it will meet the following requirements:* • *Subsections 3.2(G)(4)(f), (g), (i) and (j) in Rule 9-03;* • *Subsection 3.3(C)(4)(a) and portions of Subsection 3.3(C)(4)(b) in Rule 9-03;* • *Subsections 3.3(P)(2)(g), (i), (j) and (k) [except for (k)(ii)] in Rule 9-03; and* • *Section 8 (B) in Rule H-2011-01.*

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	In addition, use of the template will result in partial compliance with Subsections 3.3(C)(5) and (6); and 3.3(D)(1-7), (10-12), and (14-15). **Deeming Opportunity:** MCO fully meets NCQA HP UM 7 and includes the information specified in 3.2(G) 4.b, c, e, h, i, and j, and the additional information required by the ACA and associated regulations, and notifies the member that a copy of an MCO rule, guideline, protocol, or other criterion used in making the adverse determination will be provided to the member upon request and free of charge within two (2) business days or, in the case of a concurrent or urgent pre-service review, immediately upon request.	
	1 = Does not meet	**2 = Meets**
3.3 3.3 (A)	Grievance Procedures. Each managed care organization shall establish and maintain a grievance review process that provides a member with a reasonable opportunity for a full and fair review of the grievance, for members who are dissatisfied with the availability, delivery or quality of their health care services, including adverse benefit determinations, claims payments, the handling of or reimbursement for such services, or any other matter pertaining to their contractual relationship with the managed care organization.	
	1 = Does not meet	**2 = Meets**
3.3 (B)	For purposes of this section, the following grievances shall be treated as urgent: *Clarification: If a grievance request has been determined not to be urgent, based on the exceptions in Section 3.3(B), the timeframe for completion and notification of a non-urgent grievance review for mental health and substance abuse services or other health care services shall be as specified in Section 3.3(H) (i.e., 30 calendar days after receipt of the grievance).*	
3.3 (B) 1.	all pre-service grievances related to mental health and substance abuse conditions that were handled as urgent at the review level, unless:	
3.3 (B) 1. a.	the member has authorization for the treatment in dispute such that treatment can continue uninterrupted for the duration of any non-expedited grievance(s) and independent external review, if any;	
	1 = Does not meet	**2 = Meets**
3.3 (B) 1. b.	the request is for a service scheduled sufficiently in the future such that non-expedited grievance(s) and independent external review, if any, can be completed prior to the date scheduled for the service; or	
	1 = Does not meet	**2 = Meets**
3.3 (B) 1. c.	the managed care organization otherwise has good cause to believe that it is not medically necessary to expedite the timeframe for grievance review, and the member and provider agree;	
	1 = Does not meet	**2 = Meets**
3.3 (B) 2.	all pre-service pharmacy benefit grievances, unless:	
3.3 (B) 2. a.	the member has a sufficient supply of the medication in dispute to ensure that treatment can continue uninterrupted for the duration of any non-expedited grievance(s) and independent external review, if any; or	
	1 = Does not meet	**2 = Meets**

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3.3 (B) 2. b.	the managed care organization otherwise has good cause to believe that it is not medically necessary to expedite the timeframe for grievance review, and the member and provider agree;	
	1 = Does not meet	**2 = Meets**
3.3 (B) 3.	all pre-service requests related to whether use of a prescription drug for the treatment of cancer is medically necessary or is an experimental or investigational use; and	
	1 = Does not meet	**2 = Meets**
3.3 (B) 4.	any grievance designated as urgent by a member's health care provider or by the member.	
	1 = Does not meet	**2 = Meets**
3.3 (C)	Managed care organizations shall provide no more than two (2) levels of grievance, the second level of which shall be voluntary to the member. *<u>Clarification</u>**:** The Department has determined that federal regulations that forbid insurers from offering second level appeals to members of non-grandfathered individual health insurance plans are more protective of consumers, and that managed care organizations therefore cannot offer voluntary second levels of appeal to their members who are in grandfathered individual plans. For more information about the federal regulations, see volume 75, number 141 of the **Federal Register** (Friday, July 23, 2010). In particular, there is information about individual health insurance coverage and second level appeals on pages 43334 and 43340. (P. Jones' memo 12-20-11)*	
	1 = Does not meet	**2 = Meets**
3.3 (C) 1.	With respect to the voluntary second level grievance, the managed care organization shall: waive any right to assert that a member has failed to exhaust administrative remedies because the member did not elect to pursue the voluntary second level grievance; *<u>Clarification</u>: This requirement is equivalent to 3.3 (D) 13.*	
	1 = Does not meet	**2 = Meets**
3.3 (C) 2.	agree that any statute of limitations or other defense based on timeliness is tolled during the time that a voluntary second level grievance is pending;	
	1 = Does not meet	**2 = Meets**
3.3 (C) 3.	require that members who choose to elect the voluntary second level grievance may do so only after exhaustion of the required first level grievance process;	
	1 = Does not meet	**2 = Meets**
3.3 (C) 4.	provide sufficient information regarding the voluntary second level grievance process to enable the member to make an informed judgment about whether to pursue the voluntary second level grievance, including:	

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3.3 (C) 4. a.	a statement that the decision of a member as to whether or not to pursue the voluntary second level grievance will have no effect on the member's rights to any other benefits; and	
	1 = Does not meet	**2 = Meets**
3.3 (C) 4. b.	information about the applicable rules, the member's right to representation[4,5], the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker; *<u>Clarification</u>: The Department has decided that this statement does not need to be included in the Notice of Appeal Rights letter at the current time.*	
	1 = Does not meet	**2 = Meets**
3.3 (C) 5.	not impose any fees or costs on a member or provider who elects to pursue a voluntary second level grievance;	
	1 = Does not meet	**2 = Meets**
3.3 (C) 6.	include the right of the member to meet with one (1) or more of the reviewers, at the member's request, before a final determination is made on the voluntary second level grievance. The managed care organization shall provide for either an in-person meeting or a telephone meeting; however, if it is inconvenient for the member to participate in the manner offered by the managed care organization, the other method of meeting must be made available to the member. The member's treating provider(s) and any other person(s) requested by the member is (are) entitled but not required to participate in such a meeting or call. The meeting date shall be arranged in consultation with the member. The managed care organization shall not unreasonably deny a request for postponement of the review made by a member. The right to have a voluntary second level grievance considered shall not be made conditional on a member's appearance either in person or by telephone at such a meeting.	
	1 = Does not meet	**2 = Meets**
3.3 (D)	The grievance process of a managed care organization will not be deemed to provide a member with a reasonable opportunity for a full and fair review of a grievance unless the grievance process:	
3.3 (D) 1.	provides members at least one hundred eighty (180) calendar days following receipt of a notification of an adverse benefit determination within which to request a first level grievance and at least ninety (90) calendar days following receipt of notification of an adverse determination on a first level grievance within which to request a voluntary second level grievance; **Deeming Opportunity:** MCO fully meets NCQA HP UM 8, Element B and Element C, <u>and</u> provides members at least ninety (90) calendar days following receipt of notification of an adverse determination on a first level grievance within which to request a voluntary second level grievance.	

[4] The Department accepts a statement from a provider that he or she is acting on behalf of the member. It is not necessary to have a statement from the member to that effect as well.

[5] If the provider is acting on behalf of a member, the member is not entitled to another grievance at the same level. However, the member retains the right to proceed, on his or her own, to a second level grievance or independent external review if the benefit denial was upheld in a first level grievance review where the member was represented by a provider.

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	1 = Does not meet	**2 = Meets**
3.3 (D) 2.	provides members the opportunity to submit written comments, documents, records, and other information relating to the grievance; **Deeming Opportunity:** MCO fully meets NCQA HP UM 8 and meets this requirement for members pursuing concurrent review grievances.	
	1 = Does not meet	**2 = Meets**
3.3 (D) 3.	provides that a member shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the member's grievance upon request and free of charge within two (2) business days or, in the case of a concurrent or urgent pre-service review, immediately upon request. Whether a document, record, or other information is relevant to a grievance shall be determined by reference to the definition of "relevant document, record or other information" in this rule;	
	1 = Does not meet	**2 = Meets**
3.3 (D) 4.	provides for a review that takes into account all comments, documents, records, and other information submitted by the member relating to the grievance, without regard to whether such information was submitted or considered in the initial benefit determination or during the first level grievance, in the case of a voluntary second level grievance;	
	1 = Does not meet	**2 = Meets**
3.3 (D) 5.	provides for a review that does not afford deference to the initial adverse benefit determination or the adverse determination on first level grievance, in the case of a voluntary second level grievance;	
	1 = Does not meet	**2 = Meets**
3.3 (D) 6.	ensures that the person or persons reviewing a first level grievance on behalf of the managed care organization shall not have been involved with the adverse benefit determination or other issue that is the subject of the grievance, nor shall such person or persons be the subordinate(s) of any individual who was involved with the initial determination or other issue that is the subject of the grievance; **Deeming Opportunity:** MCO fully meets NCQA HP UM 8 and meets this requirement for members pursuing concurrent review grievances.	
	1 = Does not meet	**2 = Meets**
3.3 (D) 7.	ensures that the person or persons reviewing a voluntary second level grievance on behalf of the managed care organization shall not have been involved with the adverse benefit determination or other issue that is the subject of the grievance, or the adverse determination in the first level grievance; nor shall such person or persons be the subordinate(s) of any individual who was involved with the initial determination or other issue that is the subject of the grievance or the first level grievance; **Deeming Opportunity:** MCO fully meets NCQA HP UM 9, Element C.	
	1 = Does not meet	**2 = Meets**

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3.3 (D) 8.	provides that, in deciding a first level grievance of an adverse benefit determination that is: o based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, or o based in whole or in part on any other adverse benefit determination that is an appealable decision pursuant to Vermont's independent external review laws, o the reviewers shall include at least one (1) clinical peer of the member's treating provider as defined in this Rule. The managed care organization's medical director or the medical director's designee shall offer to, and if the offer is accepted, shall directly communicate with the member's treating provider or the treating provider's designee before a resolution[6] of the grievance is made; *Clarification: The Department clarifies the meaning of "clinical peer" in the following fashion: 1. if a general internist or family practitioner does not typically provide the reviewed procedure or treatment, or does not typically diagnose or manage the medical condition under review, the review panel must include an appropriate specialist who would meet the definition of clinical peer, and 2. a Pharm. D. does not meet the definition of clinical peer, but could serve on the first level grievance panel of reviewers and assist a clinical peer during first level grievance reviews.*	
	1 = Does not meet	**2 = Meets**
3.3 (D) 9.	provides for the identification of any clinical expert(s) whose advice was obtained on behalf of the managed care organization in connection with a member's adverse benefit determination without regard to whether the advice was relied upon in making the determination; **Deeming Opportunity:** MCO fully meets NCQA HP UM 9, Element D.	
	1 = Does not meet	**2 = Meets**

[6] A grievance is considered to have been resolved when the MCO has made a decision and has provided a written description of the action it intends to take or decision that has been made to the member and provider (as applicable). It does not mean that the decision made was in favor of the member, but simply that a decision was made. Should the member appeal to an external review entity, the decision made by such an entity also constitutes a resolution of a grievance.

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3.3 (D) 10.	provides that any clinical expert(s) engaged for purposes of a consultation related to a grievance shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the grievance, or in connection with the first level grievance if the managed care organization elects to engage any clinical expert(s) for a voluntary second level grievance, nor the subordinate of any such individual;	
	1 = Does not meet	**2 = Meets**
3.3 (D) 11.	in the case of a grievance involving concurrent review or a pre-service grievance involving urgent care, provides for a review process consistent with the time frames required by this rule and permits a request for a concurrent or expedited first or voluntary second level grievance of an adverse benefit determination to be submitted orally or in writing by the member. All necessary information needed by or to be communicated by the managed care organization, including the managed care organization's benefit determination upon review, shall be accepted by the managed care organization and transmitted between it and the treating provider (if known) and/or the member in the most expeditious form and manner available;	
	1 = Does not meet	**2 = Meets**
3.3 (D) 12.	provides members who have a disability reasonable accommodations for filing grievances and for participating in the grievance process;	
	1 = Does not meet	**2 = Meets**
3.3 (D) 13.	ensures that the managed care organization waives any right to assert that a member has failed to exhaust administrative remedies because the member did not elect to submit a grievance to the voluntary second level of grievance; *Clarification: This requirement is equivalent to 3.3 (C) 1.*	
	1 = Does not meet	**2 = Meets**
3.3 (D) 14.	provides members for whom English is not a primary language with information in their primary language, if requested, about how to file a grievance and how to participate in the grievance process; and	
	1 = Does not meet	**2 = Meets**
3.3 (D) 15.	ensures that persons who are unable to file written grievances may notify the managed care organization of a grievance orally or through another alternative mechanism. The managed care organization shall be responsible for documenting such grievances and providing copies to the members for their use, or the use of the members' representatives.	
	1 = Does not meet	**2 = Meets**
3.3 (E)	For any grievances relating to an adverse benefit determination, a managed care organization shall promptly authorize and/or otherwise arrange for coverage for any covered service that had been denied or restricted and as to which a reversal has been made by its reviewers under this section.	
	1 = Does not meet	**2 = Meets**

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3.3 (F) 3.3 (F) 1.	<u>First-Level Concurrent Review Grievance - Timeframe for Completion and Notification:</u> A grievance related to a request to continue or extend a course of treatment shall be decided as soon as possible consistent with the medical exigencies of the case. A managed care organization shall notify the member and treating provider (if known) in accordance with paragraph (P) of this section of the managed care organization's determination (whether adverse or not) as soon as possible consistent with the medical exigencies of the case, but not later than twenty-four (24) hours after receipt of the grievance. <u>Clarification</u>*: For this requirement and other grievance notice requirements within 3.3 (F) through 3.3. (N) "treating provider" means the referring or rendering provider who is submitting the appeal on the member's behalf.* *In addition, for this requirement and other grievance notice requirements contained within 3.3 (F) through 3.3 (N), notification of grievance resolution should not occur if the subject of the grievance relates to multiple providers and the MCO has a reasonable basis for believing that notification to multiple providers could cause confusion and/or result in a HIPAA violation.* *Furthermore, for this requirement and other grievance requirements contained within 3.3 (F) through 3.3 (N), "if known" with respect to the treating provider means that the MCO has the treating provider's contact information in its possession or is easy to obtain through routine methods, such as phone calls, provider directory searches or internet research. The MCO is not required to do significant research that may impose an unreasonable burden to obtain the treating provider's contact information.*	
3.3 (F) 2.	Consistent with the requirements of Section 3.1(G)3 of this Rule, in the case of a grievance related to an adverse concurrent review determination, neither the member nor the provider shall be liable for any services provided before notification to the member of the adverse benefit determination and the final outcome of any grievance or independent external review, unless the treating provider or designee has refused or repeatedly failed to engage in communication with the managed care organization when it has been offered at a time in a manner reasonably convenient for the provider, in which case the provider and not the member shall be liable for any services provided.	
3.3 (F) 3.	The managed care organization shall notify the treating provider and member of the determination orally as soon as the determination has been made. Written (either hard copy or, if elected by the member or treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider and member within twenty-four (24) hours of the oral notification.	
	1 = Does not meet	**2 = Meets**
3.3 (G) 3.3 (G) 1.	<u>First-Level Urgent, Pre-Service Grievance - Timeframe for Completion and Notification:</u> In the case of a grievance relating to an urgent, pre-service request, the managed care organization shall notify the member and the member's treating provider (if known) in accordance with paragraph (P) of this section of the managed care organization's determination (whether adverse or not) as expeditiously as the member's medical condition requires, but not later than seventy-two (72) hours after receipt of the grievance.	

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3.3 (G) 2.	The managed care organization shall notify the treating provider (if known) and member of the determination orally as soon as the determination has been made. Written (either hard copy, or if elected by the member or treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider (if known) and the member within twenty-four (24) hours of the oral notification. **Deeming Opportunity for 3.3 (G) 1 and 3.3 (G) 2:** MCO fully meets NCQA HP UM 9 and written notification is sent within twenty-four (24) hours of oral notification.	
	1 = Does not meet	**2 = Meets**
3.3 (H) 3.3 (H) 1.	First-Level Non-Urgent, Pre-Service Grievance - Timeframe for Completion and Notification: In the case of a grievance relating to a non-urgent, pre-service request, the managed care organization shall notify the member and the member's treating provider (if known) in accordance with paragraph (P) of this section of the managed care organization's determination (whether adverse or not) as expeditiously as the member's medical condition requires, but not later than thirty (30) calendar days after receipt of the grievance.	
3.3 (H) 2.	Written (either hard copy or, if elected by the member or treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider (if known) and the member. **Deeming Opportunity for 3.3 (H) 1 and 3.3 (H) 2:** MCO fully meets NCQA HP UM 9 and written notification is sent to the treating provider, if known.	
	1 = Does not meet	**2 = Meets**
3.3 (I) 3.3 (I) 1.	First-Level Post-Service Grievance - Timeframe for Completion and Notification: In the case of a post-service grievance, the managed care organization shall decide and notify the member and the member's treating provider (if known) in accordance with paragraph (P) of this section of the managed care organization's determination (whether adverse or not) within a reasonable period of time but not later than sixty (60) calendar days after receipt of the grievance.	
3.3 (I) 2.	Written (either hard copy or, if elected by the member or treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider (if known) and the member. **Deeming Opportunity for 3.3 (I) 1 and 3.3 (I) 2:** MCO fully meets NCQA HP UM 9, Element B and written notification is sent to the treating provider, if known.	
	1 = Does not meet	**2 = Meets**
3.3 (J) 3.3 (J) 1.	First-Level Grievance Unrelated to an Adverse Benefit Determination - Timeframe for Completion and Notification: For grievances not related to adverse benefit determinations, members shall be notified within sixty 60 calendar days after receipt of the grievance.	
3.3 (J) 2.	Written (either hard copy or, if elected by the member, appropriately secure electronic) confirmation of the determination shall be sent to the member.	

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	1 = Does not meet	**2 = Meets**
3.3 (K) 3.3 (K) 1.	Voluntary Second-Level Concurrent Review Grievance - Timeframe for Completion and Notification: A grievance related to a request to continue or extend a course of treatment shall be decided as soon as possible consistent with the medical exigencies of the case. A managed care organization shall notify the member and treating provider (if known) in accordance with paragraph (P) of this section of the managed care organization's determination (whether adverse or not) as soon as possible consistent with the medical exigencies of the case, but not later than twenty-four (24) hours after receipt of the grievance.	
3.3 (K) 2.	Consistent with the requirements of Section 3.1(G)3 of this Rule, in the case of a grievance related to an adverse concurrent review determination, neither the member nor the provider shall be liable for any services provided before notification to the member of the adverse benefit determination and the final outcome of any grievance or independent external review, unless the treating provider or designee has refused or repeatedly failed to engage in communication with the managed care organization when it has been offered at a time in a manner reasonably convenient for the provider, in which case the provider and not the member shall be liable for any services provided.	
3.3 (K) 3.	The managed care organization shall notify the treating provider and member of the determination orally as soon as the determination has been made. Written (either hard copy, or, if elected by the member or treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider and the member within twenty (24) hours of the oral notification.	
	1 = Does not meet	**2 = Meets**
3.3 (L) 3.3 (L) 1.	Voluntary Second-Level Urgent, Pre-Service Grievance - Timeframe for Completion and Notification: In the case of a voluntary second-level grievance relating to an urgent, pre-service request, the managed care organization shall notify the member and the member's treating provider (if known) in accordance with paragraph (P) of this section of the managed care organization's determination (whether adverse or not) as expeditiously as the member's medical condition requires, but not later than seventy-two (72) hours after receipt of the voluntary second-level grievance.	
3.3 (L) 2.	The managed care organization shall notify the treating provider (if known) and member of the determination orally as soon as the determination has been made. Written (either hard copy, or, if elected by the member or treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider and the member within twenty-four (24) hours of the oral notification. **Deeming Opportunity for 3.3 (L) 1 and 3.3 (L) 2:** MCO fully meets NCQA HP UM 9, Element B and written notification is sent to the treating provider and member within twenty-four (24) hours of the oral notification.	
	1 = Does not meet	**2 = Meets**
3.3 (M) 3.3 (M) 1.	Voluntary Second-Level Non-Urgent, Pre-Service Grievance - Timeframe for Completion and Notification: In the case of a voluntary second-level grievance relating to a non-urgent, pre-service request, the managed care organization shall notify the member and the member's treating provider (if known) in accordance with paragraph (P) of this section of the managed care organization's determination (whether adverse or not) as expeditiously as the member's medical condition requires, but not later than thirty (30) calendar days after receipt of the grievance.	

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3.3 (M) 2.	Written (either hard copy or, if elected by the member or treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider (if known) and the member. **Deeming Opportunity for 3.3 (M) 1 and 3.3 (M) 2:** MCO fully meets NCQA HP UM 9, Element B and written confirmation of the determination is sent to the treating provider, if known.	
	1 = Does not meet	**2 = Meets**
3.3 (N 3.3 (N) 1.	Voluntary Second-Level Post-Service Grievance - Timeframe for Completion and Notification: In the case of a voluntary second-level post-service grievance, the managed care organization shall notify the member and the member's treating provider (if known) in accordance with paragraph (P) of this section of the managed care organization's determination (whether adverse or not) within a reasonable period of time but not later than sixty (60) calendar days after receipt of the grievance.	
3.3 (N) 2.	Written (either hard copy or, if elected by the member or treating provider, appropriately secure electronic) confirmation of the determination shall be sent to the treating provider (if known) and the member. **Deeming Opportunity for 3.3 (N) 1 and 3.3 (N) 2:** MCO fully meets NCQA HP UM 9, Element B and written confirmation of the determination is sent to the treating provider, if known.	
	1 = Does not meet	**2 = Meets**
3.3 (O) 3.3 (O) 1.	Voluntary Second-Level Grievance Unrelated to an Adverse Benefit Determination - Timeframe for Completion and Notification: For voluntary second-level grievances not related to adverse benefit determinations, members shall be notified within sixty (60) calendar days after receipt of the grievance.	
3.3 (O) 2.	Written (either hard copy or, if elected by the member, appropriately secure electronic) confirmation of the determination shall be sent to the member.	
	1 = Does not meet	**2 = Meets**
3.3 (P)	Contents of Notice of Determination on Grievance A written or electronic notification of a determination of a grievance shall set forth the following information in a manner calculated to be understood by the member:	
3.3 (P) 1.	if the grievance resulted in authorization, a clear and complete description of the service(s) that were authorized and all applicable limitations or conditions;	
	1 = Does not meet	**2 = Meets**
3.3 (P) 2.	unless the previous adverse benefit determination has been completely overturned:	
3.3 (P) 2. a	the titles and qualifying credentials of the person or persons reviewing the grievance on behalf of the managed care organization; **Deeming Opportunity:** MCO fully meets NCQA HP UM 9	
	1 = Does not meet	**2 = Meets**

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3.3 (P) 2. b	a statement of the reviewers' understanding of the member's grievance;	
	1 = Does not meet	**2 = Meets**
3.3 (P) 2. c.	the specific reason or reasons for the adverse determination; **Deeming Opportunity:** MCO fully meets NCQA HP UM 9	
	1 = Does not meet	**2 = Meets**
3.3 (P) 2. d.	the text of the specific health benefit plan provisions on which the determination is based;	
	1 = Does not meet	**2 = Meets**
3.3 (P) 2. e.	if the adverse benefit determination is based on medical necessity, an experimental/investigational exclusion, is otherwise an appealable decision pursuant to Vermont's independent external review laws, or is otherwise a medically-based determination, an explanation of the scientific or clinical judgment for the determination, and an explanation of how the clinical review criteria and the terms of the health benefit plan apply to the member's medical circumstances;	
	1 = Does not meet	**2 = Meets**
3.3 (P) 2. f.	if the grievance is concurrent or pre-service, what, if any, alternative covered benefits the managed care organization considers to be medically necessary and would authorize if requested;	
	1 = Does not meet	**2 = Meets**
3.3 (P) 2. g.	a statement that the member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the member's grievance within two (2) business days or, in the case of a concurrent or urgent pre-service grievance, immediately upon request. Whether a document, record, or other information is relevant to a grievance shall be determined by reference to the definition of "relevant document, record or other information" in this rule; **Deeming Opportunity:** MCO fully meets NCQA HP UM 8, Element B and C, and includes in the notification that the materials will be provided within two business days, or in the case of concurrent or urgent pre-service grievance, immediately upon request and free of charge.	
	1 = Does not meet	**2 = Meets**
3.3 (P) 2. h.	if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to the member upon request and free of charge within two (2) business days or, in the case of a concurrent or urgent pre-service review, immediately upon request; **Deeming Opportunity:** MCO fully meets NCQA HP UM 8, Element B and C, and includes in the notification that the materials will be provided within two business days, or in the case of concurrent or urgent pre-service grievance, immediately upon request and free of	

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	charge.	
	1 = Does not meet	**2 = Meets**
3.3 (P) 2. i.	notice of the right to obtain independent external review, in the language, format and manner prescribed by the Department;	
	1 = Does not meet	**2 = Meets**
3.3 (P) 2. j	the local and toll-free numbers for the Department's health care consumer assistance section and the Vermont Office of Health Care Ombudsman;	
	1 = Does not meet	**2 = Meets**
3.3 (P) 2. k.	in the notice of decision after a first level grievance, a statement describing the voluntary second level of grievance that is available to the member, with sufficient information to enable the member to make an informed judgment about whether to pursue the voluntary second level grievance, including:	
	1 = Does not meet	**2 = Meets**
3.3 (P) 2. k. i	a statement that the decision of a member as to whether or not to pursue the voluntary second level grievance will have no effect on the member's rights to any other benefits or to pursue independent external review;	
	1 = Does not meet	**2 = Meets**
3.3 (P) 2. k.ii	a description of the requirements and timeframes for filing the voluntary second level grievance and/or a request for independent external review in order for the member or provider to be held harmless pending the outcome;	
	1 = Does not meet	**2 = Meets**
3.3 (P) 2.k.iii	information regarding the voluntary second level grievance, including the applicable rules, the member's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker;	
	1 = Does not meet	**2 = Meets**
3.3 (P) 2.k.iv	a statement that there are no fees or costs for a member or provider who elects to pursue a voluntary second level grievance.	
	1 = Does not meet	**2 = Meets**
3.3 (Q)	A managed care organization plan shall maintain written or electronic records documenting all grievances (the grievance register) received during a calendar year. The managed care plan shall retain the grievance register compiled for a calendar year for at least three (3) years. Each grievance register shall contain, at a minimum, the following information:	
3.3 (Q) 1.	the identity of the member who filed the grievance, using a unique identification code assigned consistently to that member;	
	1 = Does not meet	**2 = Meets**
3.3 (Q) 2.	a general description of the reason for the grievance;	
	1 = Does not meet	**2 = Meets**

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3.3 (Q) 3.	the date the grievance was received by the managed care organization;	
	1 = Does not meet	**2 = Meets**
3.3 (Q) 4.	the date of each review and hearing (if any);	
	1 = Does not meet	**2 = Meets**
3.3 (Q) 5.	whether the grievance was resolved through the first level of review, or whether it was subject to a second level grievance or independent external review;	
	1 = Does not meet	**2 = Meets**
3.3 (Q) 6.	whether, and if so when, the managed care organization or member requested an extension, and documentation that the member agreed to the extension;	
	1 = Does not meet	**2 = Meets**
3.3 (Q) 7.	whether additional information was requested, and the date the information necessary to resolve the grievance was received if an extension was requested; and	
	1 = Does not meet	**2 = Meets**
3.3 (Q) 8.	the resolution of the grievance along with the date it was resolved.	
	1 = Does not meet	**2 = Meets**
4.1	Required Disclosures Specific to Pharmaceutical Benefits. In addition to providing the information required by Section 2.2 (A) 3 r of this rule, a managed care organization and any responsible delegate shall ensure that the primary source of information for members and providers regarding drugs subject to a pharmaceutical benefit management program (PBMP) includes a description of or reference to:	
4.1 (A)	where applicable, the particular clinical indications for which the PBMP applies (or does not apply) for use of a drug that has multiple indications for use;	
	1 = Does not meet	**2 = Meets**
4.1 (B)	the nature of the clinical information required; by whom, how and where the information must be submitted; how to confirm receipt; and contact information for customer service as well as telephone, fax and other contact information for the reviewing entity(ies), in order to request:	
4.1 (B) 1.	prior authorization;	
4.1 (B) 2.	exceptions from PBMP criteria; and	
4.1 (B) 3.	a grievance related to a PBMP.	
	1 = Does not meet	**2 = Meets**

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4.2 4.2 (A)	<u>Procedures Regarding Changes To Pharmaceutical Benefits</u> Whenever a change is made in a PBMP that applies a new or revised dose restriction that causes a prescription for a particular drug not to be covered for the number of doses prescribed, or applies a new or revised substitution, step therapy, prior authorization or any other requirement that causes a particular drug not to be covered until the requirements of that PBMP have been met, the managed care organization and any responsible delegate shall ensure:	
4.2 (A) 1.	the change is published in the primary source of PBMP information for members and providers as long in advance as possible but no less than ninety (90) days prior to the effective date of the change; *Clarification: If a change is made to a PBMP that applies new or revised dose restrictions, or applies a new or revised substitution, step therapy, prior authorization or any other requirement, regardless of whether it adversely affects the member, the change must be published in the primary source of PBMP information for members and providers as long in advance as possible but no less than ninety (90) days prior to the effective date of the change*.	
	1 = Does not meet	**2 = Meets**
4.2 (A) 2.	each member who is known to have an active prescription for the drug is individually notified in writing at least ninety (90) days[7] prior to the effective date of the change; and <u>*Clarification:*</u> *If a change is made to a PBMP requirement that applies new or revised dose restrictions, or applies a new or revised substitution, step therapy, prior authorization or any other requirement, which does not otherwise adversely affect members who have active prescriptions from obtaining a particular medication, the member does not need to be individually notified in writing prior to the effective date of the change.*	
	1 = Does not meet	**2 = Meets**
4.2 (A) 3.	that if a member requests a fill or refill of a prescription written prior to publication of the change or receipt of the notice required by Subsection (A)1 or (2) of this section; the prescription remains valid; and it is not possible to timely obtain a prescription consistent with the changed requirement, coverage will be provided for an interim supply of the drug and, if relevant, any additional supply that is medically necessary to safely discontinue the drug for up to ninety (90) days or until the prescribing provider can order a new prescription; or, if necessary, until the grievance and independent review process can be initiated and completed.	
	1 = Does not meet	**2 = Meets**

[7] Day means calendar day unless otherwise noted**.**

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4.3 4.3 (A)	Utilization Management and Grievance Programs and Procedures Specific to Pharmaceutical Benefits A managed care organization and any responsible delegate shall review relevant clinical evidence, consult with individual(s) with relevant expertise in pharmacology and/or pharmacy and with health care providers in the same or similar specialties that typically provide and manage the drug regimens subject to the PBMP and proactively assess, on an ongoing basis:	
4.3 (A) 1.	the appropriateness of its selection of particular PBMP procedures for particular drugs in particular medical situations;	
	1 = Does not meet	**2 = Meets**
4.3 (A) 2.	whether the PBMP procedures it has applied to particular drugs may create a risk of unintended detrimental clinical outcomes in particular medical situations; and	
	1 = Does not meet	**2 = Meets**
4.3 (A) 3.	whether complaints, appeals or other feedback from members and providers indicate a need to improve the usability or reduce the burden of its PBMP procedures.	
	1 = Does not meet	**2 = Meets**
4.3 (B)	A managed care organization shall grant an exception to a PBMP requirement and shall provide coverage on the same terms as it would have for the PBMP requirement if the member's prescribing health care provider certifies, based on relevant clinical information about the particular member and sound medical or scientific evidence or the known characteristics of the drug, that the PBMP requirement:	
4.3 (B) 1.	has been ineffective or is reasonably expected to be ineffective or significantly less effective in treating this member's condition such that an exception is medically necessary; or	
4.3 (B) 2.	has caused or is reasonably expected to cause adverse or harmful reactions in this member.	
	1 = Does not meet	**2 = Meets**
4.3 (C)	A managed care organization may require a prescribing provider to submit the request for an exception and supporting certification in writing in advance in non-emergency situations if the format and process for submitting written certification facilitates the transmission of necessary information without creating barriers to timely treatment or requiring additional steps or a greater investment of time by the provider in fulfilling other requirements for utilization management, except that:	
4.3 (C) 1.	a managed care organization shall accept the advance certification telephonically in a situation designated by the prescribing provider to be an emergency but may require that it later be confirmed in writing;	
	1 = Does not meet	**2 = Meets**
4.3 (C) 2.	a managed care organization may accept but shall not require submission of actual medical records that duplicate information provided in the certification unless there is a reason to suspect that that the information in the certification is inaccurate.	
	1 = Does not meet	**2 = Meets**
4.3 (D)	In addition to the requirements of Sections 2.2, 3.2 and 3.3 of this rule, plan documents and notices of an adverse benefit determination related to a prescribed drug shall include a detailed explanation of:	
4.3 (D) 1.	the information required to be submitted to comply with PBMP requirements for requesting exceptions from PBMP criteria and, if necessary, to file a grievance related to a PBMP;	

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	1 = Does not meet	**2 = Meets**
4.3 (D) 2.	by whom the request and clinical or other required information is to be submitted;	
	1 = Does not meet	**2 = Meets**
4.3 (D) 3.	how and where information must be submitted, including telephone, fax and other contact information for the reviewing entity(ies);	
	1 = Does not meet	**2 = Meets**
4.3 (D) 4.	under what circumstances and how an interim supply of medication may be obtained; and	
	1 = Does not meet	**2 = Meets**
4.3 (D) 5.	the fact that a denial of a request for a PBMP exception is a determination subject to independent external review under Vermont law, and shall include any applicable notice required by the Department and a reference to descriptions of the independent external review process in relevant plan documents.	
	1 = Does not meet	**2 = Meets**
4.3 (E)	As long as a drug continues to be prescribed for a member and is considered safe for the treatment of the member's condition, a member who has previously been prescribed an otherwise covered drug that is the subject of PBMP prior authorization, other review and/or denial shall be entitled to coverage for a supply of the drug sufficient to continue treatment through the following time periods, as well as any additional supply that is medically necessary to safely discontinue the drug if the denial is ultimately upheld:	
	1 = Does not meet	**2 = Meets**
4.3 (E) 1.	until the PBMP has completed the prior authorization or other review process;	
	1 = Does not meet	**2 = Meets**
4.3 (E) 2.	if applicable, until all requested internal expedited grievances have been exhausted; and	
	1 = Does not meet	**2 = Meets**
4.3 (E) 3.	until the independent external review decision is issued, if expedited independent external review is requested within twenty-four (24) hours of the receipt of the final grievance decision and notice of appeal rights by the member, and expedited independent external review is conducted in accordance with the time frames specified by law.	
	1 = Does not meet	**2 = Meets**
4.3 (F)	Whenever an exception has been made or a denial of coverage for a prescription drug is overturned as a result of a grievance or independent external review, the managed care organization shall not require utilization review for a refill or a new prescription to continue using the same drug as long as:	
4.3 (F) 1.	the member's prescribing provider continues or reinstitutes treatment with the same drug regimen to treat the same condition of the member in the same or similar circumstances and there has been no significant change in the medical or scientific evidence supporting the exception or overturn of the denial; and	

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4.3 (F) 2.	the drug continues to be considered safe and effective for treating the member's condition.	
	1 = Does not meet	**2 = Meets**
4.3 (G)	A managed care organization shall not establish a higher tier or increase a drug's tier, co-payment or other cost-sharing requirement solely because a drug was approved for coverage following a grievance or independent external review.	
	1 = Does not meet	**2 = Meets**
5.1	Adequacy of Access to Providers and Continuity of Services Each managed care organization, either directly or through its provider contracts, shall ensure that covered health care services are accessible to members on a timely basis, as follows. Each managed care organization shall contract with sufficient numbers and types of providers to ensure that all covered health care services for which there are restrictions or incentives for members to use contracted or certain other providers will be provided without unreasonable delay. This requirement must be met in all service areas where the managed care organization has members.	
	1 = Does not meet	**2 = Meets**
5.1 (A)	Travel time standards Travel times for members of a managed care organization to contracted providers, under normal conditions from their residence or place of business, generally should not exceed the following:	
5.1 (A) 1.	thirty (30) minutes to a primary care provider;	
	1 = Does not meet	**2 = Meets**
5.1 (A) 2.	thirty (30) minutes to routine, office-based mental health and substance abuse services;	
	1 = Does not meet	**2 = Meets**
5.1 (A) 3.	sixty (60) minutes for outpatient physician specialty care; intensive outpatient, partial hospital, residential or inpatient mental health and substance abuse services; laboratory; pharmacy; general optometry; inpatient; imaging; and inpatient medical rehabilitation services;	
	1 = Does not meet	**2 = Meets**
5.1 (A) 4.	ninety (90) minutes for kidney transplantation; major trauma treatment; neonatal intensive care; and tertiary-level cardiac services, including procedures such as cardiac catheterization and cardiac surgery; and	
	1 = Does not meet	**2 = Meets**
5.1 (A) 5.	reasonable accessibility for other specialty services, including major burn care, organ transplantation (other than kidneys), and specialty pediatric care. This section shall not be construed as restricting or prohibiting a managed care plan from offering such services at so-called "centers of excellence" inside or outside of the service area, as long as the selection of a center of excellence is based on objective quality of care indicators and as long as the benefits are such that it does not create foreseeable medical, practical or financial impediments for the member to be able to timely obtain access to related immediate, episodic and/or ongoing care.	
	1 = Does not meet	**2 = Meets**

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5.1 (B)	Waiting time standards[8],[9],[10] Waiting times should generally not exceed the following:	
5.1 (B) 1.	immediate access to emergency care for conditions that meet the definition of "emergency medical condition" set forth in this rule, subject to the provisions of Section 2.4 of this rule;	
	1 = Does not meet	**2 = Meets**
5.1 (B) 2.	twenty-four (24) hours or a time frame consistent with the medical exigencies of the case for urgent care (for the purposes of this subsection, outpatient mental health and substance abuse care designated by the member or provider as non-urgent is not considered to be urgent care);	
	1 = Does not meet	**2 = Meets**
5.1 (B) 3.	two (2) weeks for non-emergency, non-urgent care;	
	1 = Does not meet	**2 = Meets**
5.1 (B) 4.	ninety (90) days for preventive care (including routine physical examinations); and	
	1 = Does not meet	**2 = Meets**
5.1 (B) 5.	thirty (30) days for routine laboratory, imaging, general optometry, and all other routine services.	
	1 = Does not meet	**2 = Meets**
5.1 (C)	Each managed care organization shall develop and implement written standards or guidelines that address the assessment of contracted provider capacity to provide timely access to health care services.	
	1 = Does not meet	**2 = Meets**
5.1 (D)	Each managed care organization shall, either directly or through contracts or other arrangements, provide the services of primary care providers sufficient to respond to initial and basic care needs of members.	
	1 = Does not meet	**2 = Meets**

[8] An MCO has three options for measuring compliance with this standard. It can:

1. conduct an annual survey of members (using the HEDIS/CAHPS Adult Survey for physical health and using the Vermont Mental Health and Substance Abuse Services Experience of Care Survey for behavioral health);
2. survey (review) appointment books in PCP and behavioral health care offices, or
3. survey PCP and behavioral health care offices and pose as MCO members seeking appointments.

[9] If relying on the option of the annual survey of members, MCOs must use the responses to Question 4 of the CAHPS 5.0H Adult Commercial Questionnaire to document compliance with this requirement.

[10] If relying on the option of the annual survey of members, MCOs must use the responses to the appropriate question in the Vermont Mental Health and Substance Abuse Services Experience of Care Survey to document compliance with this requirement.

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5.1 (E)	Each managed care organization shall permit its members to make at least two (2) visits per calendar year to a contracted gynecological health care provider for reproductive or gynecological care, as well as visits relating to follow-up care for problems identified during such visits, without a referral from the members' primary care providers. All such visits shall be subject to the utilization review procedures used by the managed care organization in accordance with Section 3.2 of this rule.	
	1 = Does not meet	**2 = Meets**
5.1 (F)	Each managed care organization shall permit certain new members to continue to use their previous providers, so long as those providers agree to abide by the health benefit plan's payment rates, quality-of-care standards and protocols, and to provide the necessary clinical information to the managed care organization, as follows:	
5.1 (F) 1.	new members with life-threatening[11], disabling[12] or degenerative[13] conditions shall be allowed to continue to see their providers for sixty (60) days from the date of enrollment or until accepted by a contracted provider, whichever is shorter; and	
	1 = Does not meet	**2 = Meets**
5.1 (F) 2.	women in their second or third trimester of pregnancy shall be allowed to continue to obtain care from their previous provider until the completion of postpartum care.	
	1 = Does not meet	**2 = Meets**
5.1 (G)	The managed care organization shall establish policies and procedures to ensure the orderly transfer of those members whose providers' contracts with the health benefit plan have expired or been terminated, with or without cause, to other contracted providers. In so doing, each managed care organization shall permit certain members receiving an ongoing course of treatment to continue to use providers whose contracts have been terminated without cause, or whose contracts have not been renewed without cause, so long as those providers agree to abide by the health benefit plan's payment rates, quality-of-care standards and protocols, and to provide the necessary clinical information to the managed care organization, as follows:	
5.1 (G) 1.	members with life-threatening, disabling or degenerative conditions shall be allowed to continue to see their providers for sixty (60) days from the date of termination or non-renewal or until accepted by a contracted provider, whichever is shorter; and	
	1 = Does not meet	**2 = Meets**
5.1 (G) 2.	women in their second or third trimester of pregnancy shall be allowed to continue to obtain care from their previous provider until the completion of postpartum care. **Deeming Opportunity:** MCO fully meets NCQA HP QI 10, Element D.	
	1 = Does not meet	**2 = Meets**

[11] A life-threatening condition is a disease or condition likely to be the proximate cause of death.
[12] A disabling condition is a disease or condition that alters the individual's ability to a) function in his or her occupation, b) control his or her activities of daily living, and/or c) function within society.
[13] A degenerative condition is a disease or condition recognized in the medical literature for progressive deterioration of any body part, organ, or system.

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5.1 (H)	In the event that a primary care provider referral is needed for access to specialty care, a managed care organization shall establish policies and procedures through which a member with a condition that requires ongoing care from a specialist may obtain a standing referral to a contracted specialist, subject to the utilization review procedures used by the managed care organization in accordance with Section 3.2 of this rule. For purposes of this provision, "standing referral" means a referral for ongoing care to be provided by a contracted specialist that authorizes a series of visits with the specialist for either a specific time period or a limited number of visits, and which is provided according to a treatment plan developed by the member's primary care provider, the specialist, the member and the managed care organization(s). The term "specialist" includes specialists in the treatment of mental health and/or substance abuse conditions and disorders.	
	1 = Does not meet	**2 = Meets**
5.1 (I)	In the event that a primary care provider referral is needed for access to specialty care, a managed care organization shall establish policies and procedures through which a member who has either a life-threatening condition or disease, or a degenerative or disabling condition or disease, that requires specialized health care over a prolonged period of time may receive a referral to a contracted specialist or a contracted specialized facility with expertise in treating the condition or disease, who shall be responsible for and capable of providing and coordinating the member's primary and specialty care. The specialist or specialized facility shall be permitted to treat the member without a referral from the member's primary care provider and may authorize such referrals and health care services as the member's primary care provider would otherwise be permitted to provide or authorize, subject to the utilization review procedures used by the managed care organization in accordance with this rule.	
	1 = Does not meet	**2 = Meets**
5.1 (J)	A managed care organization shall ensure that members may obtain covered services from contracted or non-contracted health care providers within or outside of the service area of the member's health benefit plan when the managed care organization or an independent external review process conducted pursuant to Vermont law determines that the managed care organization does not have a contracted health care provider with appropriate training and experience to provide the services that are medically necessary to meet the particular health care needs of the member, subject to the utilization review procedures used by the health benefit plan in accordance with this rule. In this circumstance:	
5.1 (J) 1.	the managed care organization shall assist the member by locating a provider that is contracted, otherwise affiliated or willing to arrange a single case agreement and that has the appropriate training and experience to provide the services that are medically necessary to meet the particular health care needs of the member. Any such provider shall be in a location that is reasonably accessible to the member consistent with the member's medical circumstances if the provider does not meet the travel time standards specified in this rule.	
	1 = Does not meet	**2 = Meets**
5.1 (J) 2.	If no provider meeting the specifications described in Subsection (J)1 of this section is available and accessible to the member on a timely basis, the managed care organization shall provide the member with coverage for services from a non-contracted provider. Coverage shall be consistent with the terms and conditions for coverage of services obtained from a contracted provider within the service area.	
	1 = Does not meet	**2 = Meets**

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5.1 (J) 3.	Coverage required pursuant to this subsection shall be without any additional liability to the member whether the service is provided by a contracted or non-contracted provider. The member shall not be responsible for any additional costs incurred by the managed care organization under this paragraph other than any copayment, coinsurance or deductible applicable to the level of coverage required by this subsection.	
	1 = Does not meet	**2 = Meets**
5.1 (K)	When a member or subscriber temporarily lives, works, attends school or otherwise temporarily resides outside of the service area, requires medically necessary services that would be covered under the health benefit plan if the member were able to access care from contracted providers within the service area, and it is medically necessary that the services be provided promptly, locally and not delayed until the member's return to the service area, the managed care organization shall:	
5.1 (K) 1.	assist the member in locating a provider in the member's location that is contracted, otherwise affiliated or willing to arrange a single case agreement and that has the appropriate training and experience to provide the services that are medically necessary to meet the particular health care needs of the member. Coverage shall be consistent with the terms and conditions of the member's certificate for coverage of services obtained from a contracted provider within the service area. There shall be no additional liability to the member.	
	1 = Does not meet	**2 = Meets**
5.1 (K) 2.	If no provider that has the appropriate training and experience to provide the services that are medically necessary to meet the particular health care needs of the member in the member's location is contracted, affiliated or willing to arrange a single case agreement, the managed care organization shall:	
5.1 (K) 2. a.	provide clear notice to the member that the member may be liable for any balance between the amount paid or reimbursed by the managed care organization and the non-contracted provider's charges, and provide the member with coverage consistent with the terms and conditions in the member's certificate, if the certificate allows for coverage of the service outside of the service area;	
	1 = Does not meet	**2 = Meets**
5.1 (K) 2. b.	provide clear notice to the member that the member may be liable for any balance between the amount paid or reimbursed by the managed care organization and the non-contracted provider's charges, and provide the member with coverage consistent with the terms and conditions in the member's certificate for coverage of services within the service area, if the certificate does not ordinarily allow for coverage of the service outside of the service area; and	
	1 = Does not meet	**2 = Meets**

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5.1 (K) 2. c.	pay or reimburse the non-contracted provider for services provided subject to this subsection the reasonable and customary value for the health care services rendered. If the managed care organization has complied with its obligations under this section, it is not required to assume liability if the non-contracted provider seeks additional compensation.	
	1 = Does not meet	**2 = Meets**
5.2 5.2 (A)	Credentialing Verification Practices Each managed care organization shall verify the credentials of all contracted health care providers. The managed care organization shall establish procedures to review and evaluate provider credentials both upon application of the health care provider to become employed by or to contract with the managed care organization and at least once every three (3) years thereafter. The initial verification of credentials or provisional credentialing shall be completed before entering into the employment or contractual relationship.[14] Full credentialing shall be completed prior to the managed care organization's listing a health care provider as a contracted provider in any marketing and member materials. *Clarification: Consistent with NCQA requirements, MCOs are not required to credential "practitioners who practice exclusively within the inpatient setting and provide care to…[MCO] members only as a result of members being directed to the hospital or another inpatient setting." Excluded providers may include radiologists, anesthesiologists, pathologists, ER physicians, hospitalists, neonatologists and telemedicine consultants.* **Deeming Opportunity:** MCO fully meets NCQA HP CR 1 and CR 4 and full credentialing shall be completed prior to the managed care organization's listing a health care provider as a contracted provider in any marketing and member materials. **Deeming Opportunity**: MCO fully meets URAC Health Plan Standards Version 7.0 P-CR-1 Practitioner and Facility Credentialing and full credentialing shall be completed prior to the managed care organization's listing a health care provider as a contracted provider in any marketing and member materials, including provider directories.	
	1 = Does not meet	**2 = Meets**

[14] In instances in which an MCO wishes to consider the provider(s) of one PHO (or delegate) to be available within another plan PHO (or delegate), the MCO must follow one of the following courses of action:

1) prior to making the provider(s) available within the other MCO PHO/delegate, ensure that the provider(s) become credentialed by PHO/delegate B, or,
2) allow PHO/delegate B to sub-delegate credentialing for providers practicing at both PHO/delegate A and PHO/delegate B sites if: a) PHO/delegate A and PHO/delegate B are both MCO contractors; b) the MCO has approved the sub-delegation arrangement in writing, and c) there are specific written responsibilities and processes for either the MCO or PHO/delegate B to oversee credentialing performance of PHO/delegate A for the affected providers.

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5.2 (B)	Each managed care organization shall establish a credentialing verification committee consisting of licensed physicians and other health care providers to review credentialing information and supporting documents and make decisions regarding credentialing verification. The medical director of the managed care organization shall be responsible for, and participate in, health care provider credentialing verification. **Deeming Opportunity:** MCO fully meets NCQA HP CR 1, CR 2 and CR 4. **Deeming Opportunity:** MCO fully meets URAC Health Plan Standards Version 7.0 P-CR-3 Credentialing Committee and the medical director of the managed care organization shall be responsible for, and participate in, health care provider credentialing verification.	
	1 = Does not meet	**2 = Meets**
5.2 (C)	Each managed care organization shall develop and maintain credentialing criteria to be used in evaluating each provider application consistent with the requirements of this rule. These criteria, and the managed care organization's credentialing verification policies and procedures, shall be made available to contracted providers and provider applicants upon written request. **Deeming Opportunity:** MCO fully meets NCQA HP CR 1 and these criteria, and the managed care organization's credentialing verification policies and procedures, shall be made available to contracted providers and provider applicants upon written request.	
	1 = Does not meet	**2 = Meets**
5.2 (D)	Except as otherwise provided by law, all information obtained in the credentialing process shall be kept confidential, except that it shall be subject to review and correction of any erroneous information by the health care provider whose credentials are being verified. Records and documents relating to a health care provider's credentialing verification process shall be retained by the managed care organization for at least three years. **Deeming Opportunity:** MCO fully meets NCQA HP CR 1 and records and documents relating to a health care provider's credentialing verification process shall be retained by the managed care organization for at least three years. **Deeming Opportunity:** MCO fully meets URAC P-CR 6 Credentialing Confidentiality and records and documents relating to a health care provider's credentialing verification process shall be retained by the managed care organization for at least three years.	
	1 = Does not meet	**2 = Meets**
5.2 (E)	Initial Credentialing: Prior to employing or contracting with a health care provider seeking to become a contracted provider, a managed care organization shall:	

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5.2 (E) 1.	obtain primary verification of at least the following information regarding individual health care providers, to the extent applicable: current license to practice; professional liability coverage; at least five (5) years' history of professional liability claims that resulted in settlements or judgments paid on behalf of the provider; status of hospital privileges; specialty board or other certification status; current Drug Enforcement Agency (DEA) registration or Controlled Dangerous Substances (CDS) certificate, as applicable; graduation from an accredited school; work history; and completion of post-graduate training; **Deeming Opportunity:** MCO fully meets NCQA HP CR 3 and obtains primary verification of professional liability coverage and status of hospital privileges. **Deeming Opportunity:** MCO fully meets URAC Case Management Standards Version 4.0 Core 30 – Clinical Staff Credentialing or URAC Health Plan Standards Version 7.0 P-CR-5 Credentialing application and obtains primary verification of at least the following information regarding individual health care providers, to the extent applicable: current license to practice; professional liability coverage; at least five (5) years' history of professional liability claims that resulted in settlements or judgments paid on behalf of the provider; status of hospital privileges; specialty board or other certification status; current Drug Enforcement Agency (DEA) registration or Controlled Dangerous Substances (CDS) certificate, as applicable; graduation from an accredited school; work history; and completion of post-graduate training.	
	1 = Does not meet	**2 = Meets**
5.2 (E) 2.	obtain, through either primary verification or secondary verification from an approved source, to the extent applicable, the health care provider's license history in Vermont and all other states, including dates, times, and places of all applications for license privileges; any action taken on such applications; challenges to licensure or registration; the voluntary or involuntary relinquishment of a license; any state sanctions, restrictions or conditions on licensure or limitations on the scope of practice; Medicare and Medicaid sanctions; and malpractice history; *Clarification: Verification of license history requires contacting the licensing boards in Vermont and in each additional state (if any) in which the provider reported having had a current or previous license.* **Deeming Opportunity:** MCO fully meets NCQA HP CR 3 Element B and C and obtains, through either primary verification or secondary verification from an approved source, to the extent applicable, the health care provider's license history in Vermont and all other states, including dates, times, and places of all applications for license privileges; and any action taken on such applications; and challenges to licensure or registration. **Deeming Opportunity:** MCO fully meets URAC Case Management Standards Version 4.0 Core 30 – Clinical Staff Credentialing or URAC Health Plan Standards Version 7.0 P-CR-5 Credentialing application and Medicare and Medicaid sanctions; and malpractice history.	
	1 = Does not meet	**2 = Meets**

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5.2 (E) 3.	obtain and review an application and signed attestation from the provider that includes a statement that the application is correct and complete; addresses the provider's ability to perform the essential functions of the position with or without accommodation; indicates a lack of present illegal drug use; and includes any history of loss of license, felony conviction, disciplinary action and any loss/limitation of privileges; **Deeming Opportunity:** MCO fully meets NCQA HP CR 3, Element B. **Deeming Opportunity:** MCO fully meets URAC Health Plan Standards Version 7.0 P-CR-5 and addresses the provider's ability to perform the essential functions of the position with or without accommodation; indicates a lack of present illegal drug use; and includes any history of loss of license, felony conviction, disciplinary action and any loss/limitation of privileges.	
	1 = Does not meet	**2 = Meets**
5.2 (E) 4.	obtain a copy of the insurance policy declaration page from the malpractice carrier to verify current malpractice insurance coverage;	
	1 = Does not meet	**2 = Meets**
5.2 (E) 5.	with respect to a physician who has completed residency or fellowship requirements within twelve (12) months prior to anticipated employment or contract effective date and who the managed care organization determines is eligible for provisionally credentialed status, obtain primary-source verification of a current, valid license to practice; the application and attestation described in Subsection 5.2(E)3 of this rule; and the past five (5) years of malpractice claims or settlements from the malpractice carrier or the results of a National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank query. The managed care organization shall ensure that no provider remains in provisionally credentialed status for more than sixty (60) days; and **Deeming Opportunity:** MCO fully meets NCQA HP CR 1.	
	1 = Does not meet	**2 = Meets**
5.2 (E) 6.	with respect to health care facilities, obtains primary verification that confirms the provider is in good standing with applicable state and/or federal regulatory bodies and, if accredited, with the applicable accrediting entity. **Deeming Opportunity:** MCO fully meets NCQA HP CR 8, Element A.	
	1 = Does not meet	**2 = Meets**
5.2 (F)	Recredentialing: At least once every three (3) years after the initial verification of credentials, each managed care organization shall recredential each of its contracted providers in the following manner: **Deeming Opportunity:** MCO fully meets NCQA HP CR 4. **Deeming Opportunity:** MCO fully meets URAC Case Management Standards Version 4.0 Core 30 or URAC Health Plan Standards Version 7.0 P-CR-15 Recredentialing.	

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5.2 (F) 1.	obtain primary verification of current license; current DEA registration or CDS certificate, as applicable; history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the provider; and specialty board certification status, to the extent applicable; and **Deeming Opportunity:** MCO fully meets NCQA HP CR 3. **Deeming Opportunity:** MCO fully meets URAC P-CR-16 Recredentialing and Participating Provider Quality Monitoring and obtains current DEA registration or CDS certificate, as applicable; history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the provider; and specialty board certification status, to the extent applicable.	
	1 = Does not meet	**2 = Meets**
5.2 (F) 2.	obtain and review the items specified in Subsections 5.2(E)3 and 4 of this rule for individual providers; and, for health care facilities, the items specified in Subsection 5.2(E)6. **Deeming Opportunity:** MCO fully meets NCQA HP CR 3, Element B and NCQA HP CR 8, Element A. In addition, the MCO must meet 5.2 (E) 4.	
	1 = Does not meet	**2 = Meets**
5.2 (G)	Ongoing Monitoring of Credentials: The managed care organization shall implement a process for collecting and reviewing the following information between credentialing cycles, within thirty (30) days of its release or at least every six (6) months, as applicable, and shall have a policy that sets forth guidelines for appropriate intervention or disposition when it identifies instances of poor quality that could affect the health or safety of members: **Deeming Opportunity:** MCO fully meets NCQA HP CR 6.	
5.2 (G) 1.	sanctions or limitations on licensure; **Deeming Opportunity:** MCO fully meets NCQA HP CR 6.	
5.2 (G) 2.	Medicare and Medicaid sanctions; **Deeming Opportunity:** MCO fully meets NCQA HP CR 6.	
5.2 (G) 3.	complaints; and **Deeming Opportunity:** MCO fully meets NCQA HP CR 6.	
5.2 (G) 4.	information known to the managed care organization regarding injury that occurred while the member was receiving care from the provider. **Deeming Opportunity:** MCO fully meets NCQA HP CR 6.	

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	1 = Does not meet	**2 = Meets**
5.2 (H)	Each managed care organization shall require all health care providers to notify the managed care organization of any changes in the status of any of the items enumerated in this section at any time.	
	1 = Does not meet	**2 = Meets**
5.2 (I)	No managed care organization shall refuse to initially credential, or refuse to re-verify the credentials of, a health care provider solely because the provider treats a substantial number of patients who require expensive or uncompensated care.	
	1 = Does not meet	**2 = Meets**
5.2 (J)	Each managed care organization shall establish an appeal process through which a health care provider denied participation in the managed care organization may obtain review of that decision, as well as a process for the review of a decision by a managed care organization to reduce, suspend, or terminate the privileges of a contracted provider. The managed care organization shall communicate these processes to providers who have been denied participation or continuing participation with the managed care organization. The managed care organization shall document information supporting credentialing and participation decisions in providers' credentialing files. **Deeming Opportunity:** MCO fully meets NCQA HP CR 7, Element C and documents information supporting credentialing and participation decisions in provider's credentialing files.	
	1 = Does not meet	**2 = Meets**
5.3 (A)	Provider Contracting, Fiscal Incentives and Disincentives. Each managed care organization shall contract in writing with each contracted health care provider.	
	1 = Does not meet	**2 = Meets**
5.3 (B)	No managed care organization shall include any provision in a contract with a health care provider that prohibits the health care provider from disclosing to members or potential member's information about the contract or the members' health benefit plan that may affect their health or any decision regarding health.	
	1 = Does not meet	**2 = Meets**
5.3 (C)	Each managed care organization shall develop selection standards for contracted providers, including primary care providers and specialists, to be used in determining the selection of health care providers with whom the managed care organization contracts, including credentialing verification as required in Section 5.2 of this rule. Selection criteria shall not be established in a manner that would exclude providers because they treat or specialize in treating populations presenting a risk of higher-than-average claims, losses or health services utilization or provide a higher-than-average level of uncompensated care. Copies of the selection standards shall be made available to contracted providers and to the Department on request.	

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	1 = Does not meet	**2 = Meets**
5.3 (D)	Each managed care organization shall establish an appeal process through which a health care provider denied a contract with the managed care organization, or whose contract is not renewed based on its selection criteria, may obtain review of that decision. The appeal process shall include written notification to the provider of the decision against allowing contracting, or against renewal of a contract, which shall include a statement of the reasons for the managed care organization's decision not to contract or to renew the contract. It shall also include reasonable time limits for taking and resolving the appeals, and a reasonable opportunity for providers to respond to the managed care organization's statement of reasons supporting its decision not to contract or to renew a contract.	
	1 = Does not meet	**2 = Meets**
5.3 (E)	Each managed care organization shall use methods consistent with national standards to maximize the validity of provider-specific performance information and shall establish a procedure that permits health care providers to review their own results on performance measures intended for public reporting in advance of their release. The procedure shall include a reasonable opportunity for a provider to request correction of any inaccuracies prior to publication of the data and reasonable procedures and time limits for resolving any related disputes. If the performance measures are derived from claims data without any medical record review, the managed care organization, if requested by the provider, shall confirm those results with a review of medical records prior to public reporting. The managed care organization shall promptly correct inaccuracies where warranted.	
	1 = Does not meet	**2 = Meets**
5.3 (F)	No managed care organization shall prohibit a contracted provider from, or penalize a contracted provider for, o discussing treatment options with members regardless of the managed care organization's position on the treatment options, or o advocating on behalf of members within the utilization review or grievance processes established by the managed care organization, nor shall it penalize a provider because the provider in good faith reports to state or federal authorities any act or practice by the managed care organization that jeopardizes patient health or welfare.	
	1 = Does not meet	**2 = Meets**

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5.3 (G)	Each provider contract shall contain or incorporate by reference provisions clearly stating the requirements and responsibilities of the managed care organization and contracted providers with respect to administrative policies and programs, including but not limited to • payment terms, • utilization review, • quality improvement programs, • chronic care programs, • credentialing, • grievance procedures, • data reporting requirements, • confidentiality requirements, and • any other applicable provisions required by federal or state law. The contract must allow the provider to participate in the managed care organization's • quality management program, • dispute resolution process, and • utilization management program. The contract shall require contracted providers to notify the managed care organization of any changes that would impact the provider's credentialing status or ongoing availability to members.	
	1 = Does not meet	**2 = Meets**
5.3 (H)	No provider contract shall contain a provision offering an inducement to a provider to forego providing medically necessary services to a member or referring a member to such services.	
	1 = Does not meet	**2 = Meets**
5.3 (J)	Each managed care organization shall establish a mechanism for informing each contracted provider on an ongoing and current basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on the services.	
	1 = Does not meet	**2 = Meets**
5.3 (K)	Each managed care organization shall inform its primary care providers of their responsibility to provide referrals and any specific procedures that must be followed in providing referrals.	
	1 = Does not meet	**2 = Meets**

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5.3 (L)	Every contract between a provider and a managed care organization shall include a "hold harmless" provision specifying protection for the managed care organization's members in a form substantially similar to the following: "Provider agrees that in no event, including nonpayment by the managed care organization, insolvency of the managed care organization, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or a person (other than the managed care organization) acting on behalf of the member for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the certificate of coverage, or fees for uncovered services delivered on a fee-for-service basis to members. This agreement does prohibit the provider from requesting payment from a member for any services that have been confirmed by independent external review obtained through the Department of Financial Regulation pursuant to Vermont law to be medically unnecessary, experimental, investigational or a medically inappropriate off-label use of a drug."	
	1 = Does not meet	**2 = Meets**
5.3 (M)	Every contract between a managed care organization and a provider shall provide that in the event of the managed care organization's insolvency or other cessation of operations, covered services to a member will continue through the period for which a premium has been paid to the managed care organization on behalf of the member or until the member's discharge from an inpatient facility, whichever period is greater. Covered benefits to a member confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the member's continued confinement in the facility is no longer medically necessary.	
	1 = Does not meet	**2 = Meets**
5.3 (N)	The contract provisions that satisfy the requirements of paragraphs (L) and (M) of this section shall be construed in favor of the member, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the managed care organization, and shall supersede any oral or written contrary agreement between a provider and a member or member's representative if the contrary agreement is inconsistent with the "hold harmless" and continuation of covered services provisions required in those paragraphs.	
	1 = Does not meet	**2 = Meets**
5.3 (O)	A managed care organization and its contracted providers shall provide at least sixty (60) days final written notice to each other before terminating a contract without cause. Such notices shall not issue unless and until negotiations have concluded and a final decision on termination has been reached. Within five (5) working days of the date that the provider either gives or receives final notice of termination, either for or without cause, the provider shall supply the managed care organization with a list of his or her patients that are members of the managed care organization.	
	1 = Does not meet	**2 = Meets**

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5.3 (P)	After issuance or receipt of the final notice referenced in Subsection 5.3(O), the managed care organization shall provide written notice of the termination of a provider contract to all members who are patients seen on a regular basis by the provider whose contract is terminating. This notice shall be provided at least six (6) weeks prior to the anticipated date of a termination without cause, and shall be provided on or, if possible, before the date the managed care organization or provider terminates the contract for cause. Where a contract termination involves a primary care provider, all members who are patients of that provider shall also be notified. Each managed care organization shall establish procedures for the resolution of administrative, payment or other disputes between providers and the managed care organization. *Clarification: The MCO is required to notify members of contracted provider terminations only for the following providers who have delivered outpatient professional treatment in the form of two or more office visits to the member within the 12 months prior to the date of the provider's termination:* *a) primary care providers, including primary care physicians and naturopaths,* *b) specialist physicians,* *c) non-physician mental health and substance abuse clinicians; and* *d) advanced practice registered nurses, including nurse practitioners and certified nurse midwives, if the MCO's contracting criteria allows for mid-level provider billing.* *With respect to mental health and substance abuse clinicians who provide treatment at mental health agencies[15], should the MCO's contract with the agency not require billing that identifies the treating provider, the MCO shall contractually obligate the agency to provide written notice of the termination of a provider contract to all members who are patients seen on a regular basis by the provider whose contract is terminating, consistent with this requirement.*	
	1 = Does not meet	**2 = Meets**
5.3 (R)	No contract between a managed care organization and a health care provider shall contain any clause purporting to transfer to the provider, other than a medical group, by indemnification or otherwise, any liability relating to activities, actions or omissions of the managed care organization as opposed to those of the provider.	
	1 = Does not meet	**2 = Meets**
5.4 (A)	Quality Management Requirements For Managed Care Organizations Not Subject to Part 6 Each managed care organization subject to this Part but not to Part 6 of this rule shall have an internal quality management program that includes at least the following components:	

[15] See http://mentalhealth.vermont.gov/DAlist for a list of Vermont mental health agencies.

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5.4 (A) 1.	a peer review or quality management committee or comparable designated committee responsible for quality management activities; **Deeming Opportunity:** MCO fully meets NCQA HP QI 2 or URAC Case Management Standards Version 4.0 Core quality management committee.	
	1 = Does not meet	**2 = Meets**
5.4 (A) 2.	accountability of the committee to the board of directors or other governing authority of the organization;	
	1 = Does not meet	**2 = Meets**
5.4 (A) 3.	participation by an appropriate base of providers and support staff; **Deeming Opportunity:** MCO fully meets NCQA HP QI I and QI 2 or fully meets URAC Case Management Standards Version 4.0 Core 18 – quality management program resources or URAC Health Plan Standards Version 7.0 P-QM-2 quality management program resources.	
	1 = Does not meet	**2 = Meets**
5.4 (A) 4.	supervision by the medical director of the organization;	
	1 = Does not meet	**2 = Meets**
5.4 (A) 5.	regularly scheduled meetings; and **Deeming Opportunity:** MCO fully meets URAC Case Management Standards Version 4.0 Core 20 – quality management committee or URAC Health Plan Standards Version 7.0 P-QM-4 Quality Management Committee.	
	1 = Does not meet	**2 = Meets**
5.4 (A) 6.	minutes or records of the meetings, which describe in detail the actions of the committee, including problems discussed, data and other quality management findings, recommendations made, quality improvement activities implemented, the results of those activities and any other pertinent information. **Deeming Opportunity:** MCO fully meets NCQA HP QI 2 or fully meets URAC Case Management Standards Version 4.0 Core 20 – quality management committee or URAC Health Plan Standards Version 7.0 P-QM-4 quality management committee.	
	1 = Does not meet	**2 = Meets**

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6.1 (A)	Medical Records Practices. Each managed care organization shall adopt written policies and procedures that shall be available to managed care organization staff and providers in hard copy, on the internet, and in a format suitable for electronic mailing, and that address the following:	
6.1 (A) 1.	Requirements that clinical records be maintained in a manner that are current, detailed and organized, and that permit effective member care and quality review. In instances where managed care organizations do not provide care directly, they shall require their providers to maintain records in the same manner. Records may be written or electronic; and	
	1 = Does not meet	**2 = Meets**
6.1 (A) 2.	minimum content, confidentiality protections, retention, and access by members to their individual records, which shall include the right of a member to see the member's individual medical records upon request during regular business hours and to copy those records for a fee that is consistent with legal requirements. In addition, managed care organizations that provide direct patient care shall include policies that address the processing and storage of records, disposal procedures, and retrieval and distribution procedures.	
	1 = Does not meet	**2 = Meets**
6.1 (B)	The managed care organization shall have a system to access and audit the content of clinical records of high volume primary care providers at least once every three (3) years, to ensure that they are legible, organized, complete, and demonstrate compliance with any other clinical record-keeping standards established by the managed care organization. Managed care organizations or their delegates that contract with mental health providers shall perform the audit for high volume providers in at least one (1) mental health or substance abuse professional discipline with significant numbers of providers. *Clarification: MCOs may find Vermont Blueprint for Health pilot practices using EHRs to be in compliance with this requirement.*	
	1 = Does not meet	**2 = Meets**
6.2 (A)	Quality Management Program Structure and Administrative Policies and Procedures Managed care organizations shall ensure that health care services provided to their members are informed by generally accepted medical or scientific evidence, and are consistent with prevailing standards of medical practice as recognized by health care professions in the specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition. To that end, managed care organizations shall establish and implement procedures ensuring the availability, accessibility, continuity and quality of care for each member consistent with the member's clinical condition, including procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in the administration and delivery of health care services. **Deeming Opportunity:** MCO fully meets URAC Case Management Standards Version 4.0 Core 21 – quality management documentation.	
	1 = Does not meet	**2 = Meets**

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6.2 (B)	Each managed care organization shall establish an internal system capable of identifying opportunities to improve care and the managed care organization's management of care. This system shall be structured to identify practices that result in improved health care outcomes, identify problematic utilization patterns, identify those providers that may be responsible for either exemplary or problematic patterns, and foster an environment of continuous quality improvement. **Deeming Opportunity:** MCO fully meets URAC Case Management Standards Version 4.0 Core 22 – quality improvement projects and the system for identifying opportunities is structured to identify practices that result in improved health care outcomes, identify problematic utilization patterns, identify those providers that may be responsible for either exemplary or problematic patterns, and foster an environment of continuous quality improvement.	
	1 = Does not meet	**2 = Meets**
6.2 (C)	Each managed care organization shall clearly define the organizational relationships and responsibilities for quality management. **Deeming Opportunity:** MCO fully meets NCQA HP QI 1.	
	1 = Does not meet	**2 = Meets**
6.2 (D)	The medical director of the managed care organization shall have primary responsibility for the quality management activities required of, and carried out by or on behalf of, the managed care organization. The medical director shall approve the written quality management program description and annual quality management work plan, and shall periodically review and revise the program documents and act to ensure their ongoing appropriateness. The medical director shall make verbal and written quality management reports to the managed care organization's governing body at least annually. **Deeming Opportunity:** MCO fully meets NCQA HP QI 1 and requires that the medical director shall approve the written quality management program description and annual quality management work plan, and shall periodically review and revise the program documents and act to ensure their ongoing appropriateness, and shall make verbal and written quality management reports to the managed care organization's governing body at least annually.	
	1 = Does not meet	**2 = Meets**
6.2 (E)	Each managed care organization's quality management program shall include, but not be limited to, the following components:	
6.2 (E) 1.	A peer review, quality management or comparable designated committee that is responsible for the managed care organization's quality management activities. The committee shall annually review and approve, or recommend that the board of directors approve, the managed care organization's quality management program description, annual quality improvement goals, and annual quality management work plan. The committee shall also annually review the quality management program evaluation. **Deeming Opportunity:** MCO fully meets NCQA HP QI 1.	
	1 = Does not meet	**2 = Meets**

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6.2 (E) 2.	Minutes or records of the meetings of the peer review, quality management or other designated committee that describe in detail the committee's actions, including the problems discussed, data and other quality management findings, recommendations made and any other pertinent information. The minutes or records are subject to the confidentiality provisions of 26 V.S.A. § 1443, except that the Department shall have access to them as provided in 18 V.S.A. § 9414(f)(2) and Section 1.6(E) of this rule. **Deeming Opportunity:** MCO fully meets NCQA HP QI 2, Element A, and provides that the minutes or records are subject to the confidentiality provisions of 26 V.S.A. § 1443, except that the Department shall have access to them as provided in 18 V.S.A. § 9414(f)(2) and Section 1.6(E) of this rule.	
	1 = Does not meet	**2 = Meets**
6.2 (E) 3.	Accountability of the peer review, quality management or other designated committee to the board of directors or other governing authority of the managed care organization. The board shall display appropriate oversight and direction, including monitoring progress on the managed care organization's written quality management work plan and quality improvement goals.	
	1 = Does not meet	**2 = Meets**
6.2 (E) 4.	A systematic approach to seeking input from the managed care organization's contracted Vermont providers and incorporating that input into the managed care organization's quality management program. The managed care organization shall, at a minimum, include at least two (2) contracted Vermont providers on the quality management or other designated committee or maintain a committee of at least three (3) Vermont contracted providers to serve in an advisory capacity to the quality management or other designated committee, with additional specialist input as needed. If an advisory committee is selected, the managed care organization shall document that the committee provides written input to the quality management program at least annually, and that such input is considered for incorporation into the quality management program. *Clarification: An advisory committee that meets at least annually satisfies this requirement, assuming it includes at least three Vermont-contracted providers, provides written input to the quality management program at least annually, and the MCO documents that the written input was considered for incorporation into the quality management program.*	
	1 = Does not meet	**2 = Meets**
6.2 (E) 5.	A systematic approach to seeking input from the managed care organization's members and incorporating that input into the managed care organization's quality management program. The managed care organization may address this requirement by establishing a committee of at least three (3) Vermont members to serve in an advisory capacity to the quality management or other designated committee, or by annually convening focus groups of Vermont members to provide input on quality management topics. The managed care organization shall document that surveys input is at least annually received by and incorporated into the quality management program.	
	1 = Does not meet	**2 = Meets**
6.2 (E) 6.	Policies and procedures that ensure that the managed care organization's contracted providers and members expressing interest in participating in the development, implementation, and evaluation of the quality management program have the opportunity to do so.	

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	1 = Does not meet	**2 = Meets**
6.2 (E) 7.	An opportunity for members and contracted providers to comment on the quality-management process.	
	1 = Does not meet	**2 = Meets**
6.2 (F)	The managed care organization shall consult with contracted providers to develop and implement a satisfactory process to minimize the administrative burdens on providers (especially for those providers in small group practices) of implementing the quality improvement activities in Sections 6.3(B)7 and 6.3(B)8.	
	1 = Does not meet	**2 = Meets**

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6.3 6.3 (A)	Quality Management Program Description and Activities Quality Management Program: Each managed care organization shall have an internal quality management program that monitors and evaluates processes and outcomes of care for the full range of its health care services across all institutional and non-institutional settings and works with contracted providers to improve the quality of those services; and that monitors, evaluates and improves the managed care organization's service to its members and providers. A summary of the program shall be made available to managed care organization staff, contracted providers and members of a managed care organization upon request. The use of quality management program data to design incentives for members to use specific contracted providers shall not be implemented without Department approval and shall not reduce the member benefits otherwise applicable. **Deeming Opportunities:** MCO fully meets NCQA QI 1 and QI 2 and evaluates processes and outcomes of care for the full range of its health care services across all institutional and non-institutional settings, and makes available a summary of the program to managed care organization staff, and obtains Department approval prior to using quality management program data to design incentives for members to use specific contracted providers, and does not use such incentives to reduce the member benefits otherwise applicable.		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and regularly publicizes the QM program's availability to providers and members in summary form and annual changes are made to the program, incorporating feedback solicited from members, providers, and staff.
6.3 (B)	Written Quality Management Program Description: The quality management program described in Subsection 6.3(A) shall include an annual written quality management program description that describes how the managed care organization intends to:		

6.3 (B) 1.	analyze data pertaining to
	• diagnoses;
	• procedures;
	• service over-use,
	• under-use and misuse;
	• member and provider satisfaction; member grievances; and
	• member demographics to identify managed care organization practices and health care diagnoses, procedures and services
	  o that affect a substantial number of the managed care organization's members,
	  o that could place members at serious risk,
	  o that could create significant dissatisfaction among members or contracted providers, or
	  o that indicate potential opportunities for improvement.
	
	This section shall not be construed to require a managed care organization to review every disease, illness and condition that may affect a member;		

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	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			MCO meets the requirement and shares provider-specific data findings identifying opportunities for improvement regarding service over-use, under-use and misuse and member satisfaction with contracted providers at least once per year, in addition to meeting the requirements of 6.3 (B) 6, 7, and 8.
6.3 (B) 2.	analyze both processes and outcomes of care using defined measurement methodologies to discern the causes of variation;		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the standard and analyzes patient experience instrument that might include analysis of a functional health status[16] instrument to measure outcomes for at least one condition
6.3 (B) 3.	compare program findings with past performance, as appropriate, and with pre-established internal goals and external standards adopted by the managed care organization (such as industry-recognized regional and national benchmarks), where available; **Deeming Opportunities:** MCO fully meets NCQA HP QI 1, Element B and measures performance against pre-established internal goals and external standards adopted by the managed care organization (such as industry-recognized regional and national benchmarks), where available.		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and can demonstrate that establishment of the MCO's most recent internal quality improvement goals were derived from an assessment of where MCO performance varied significantly from benchmark(s).
6.3 (B) 4.	implement improvement strategies related to program findings;		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and the MCO can demonstrate three statistically significant and sustained improvements that its QI program efforts have generated in patient outcomes or processes of care in the past two years.
6.3 (B) 5.	prospectively assess the potential adverse impacts of improvement strategies on members with mental health or substance abuse conditions, and take steps to minimize such impacts;		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**

[16] Health status measurement typically assesses the function and/or wellbeing of an individual. It may be measured by an observer (e.g., a physician), who performs an examination and rates an individual along any of several dimensions, including presence or absence of life-threatening illness, risk factors for premature death, severity of disease, and overall health. A more common method of measurement is when health status is self-assessed by the patient using a tool that asks the patient to report his/her health perceptions in specified domains of interest, such as physical functioning, emotional well-being, pain or discomfort, and overall perception of health.

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			The MCO meets the standard, and establishes a standing mental health/substance abuse advisory board which is used to provide ongoing input into MCO quality improvement initiatives, and uses the input from the advisory board to develop new initiatives or the MCO prospectively assesses the impact of an improvement strategy by holding member focus groups, conducting member-only advisory group meetings, meeting with mental health/substance abuse advocates and/or meeting with mental health/substance abuse providers in advance of implementing the improvement strategies, and modifies the strategy, as necessary, based on this input.
6.3 (B) 6.	ensure that all quality improvement strategies are informed by generally accepted medical or scientific evidence, if available, and do not pose a foreseeable risk of harm to members;		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			N/A
6.3 (B) 7.	in order to improve care across the contracted provider network, use program findings to work, on a continuing basis, with contracted providers and other staff to improve the health care delivered to its members. The managed care organization shall work directly with contracted providers to continually improve performance over time, through constructive engagement, provision of motivation and support, and processes to promote accountability. Such efforts shall at a minimum include high volume contracted providers located throughout the state, and shall annually include the following: *Clarification: Compliance with requirements 6.3 (B) 7. a-f may, in part, address requirement 6.3 (D).* **Deeming opportunity**: MCO participates in Blueprint for Health as described in D.S. Bennett's October 22, 2014 memo (see Appendix I). This applies to 6.3(B)7.a-f.		

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6.3 (B) 7. a.	delivering managed care organization statewide and provider-specific performance data, including data on chronic care measures, that compare the provider to a standard, goal, or managed care organization norm, including multiple dimensions of quality where meaningful opportunities for improvement exist for two (2) or more of the following: provider accessibility, clinical quality, efficiency[17] of clinical practice and/or patient experience of care. Performance shall be measured for primary care physicians; specialist physicians; mental health and substance abuse providers; acute care hospitals; hospitals providing inpatient mental health and substance abuse services; and any other provider type specified by the Department; <u>Clarification:</u> *For now, the Department will temporarily deem the practices selected for the Common Physician Measurement project as meeting this requirement with respect to specialists. To fully meet this requirement, MCO must also work with high volume adult primary care physicians.* **Deeming opportunity:** MCO fully meets URAC Health Plan Standards Version 7.0 Network Management P-NM-Provider Network Access and Availability – establish goals, measure against goals, make improvement where necessary.		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement <u>and</u> provides performance data for at least three of the performance assessment categories: provider accessibility, clinical quality, efficiency of clinical practice and patient experience of care or provides pooled data in two categories in collaboration with at least one other MCO.
6.3 (B) 7. b.	providing performance data at the individual provider level if statistically meaningful. If the data are not statistically meaningful at the individual provider level, the managed care organization shall conduct measurement at the next level (practice site or group practice) at which it is statistically meaningful;		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			N/A

[17] Efficiency indicators include, for example, relative resource use indicators or resources used to treat a commonly defined condition or to perform a commonly defined procedure and related services.

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6.3 (B) 7. c.	reviewing and discussing performance results directly, by telephone or in person, with high-volume providers or the provider's designee; *Clarification:* • *Under this section MCOs must work with all high volume providers, not just those who do not meet the MCO's standards.* • *A provider designee may be a Practice Manager, PHO executive or a senior manager from a like organization.*		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and reviews and discusses performance results with high volume providers or the provider's designee at least twice annually or at least annually jointly reviews and discusses performance results with providers in collaboration with at least one other MCO.
6.3 (B) 7. d.	identifying opportunities for improvement and provider improvement goals based on provider performance data;		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and the MCO and its largest contracted provider organization, (e.g., ACO, PHO) agree to address at last three performance improvement goals each calendar year informed by MCO-provided or provider-derived performance data and the provider or practice has a written action plan for each goal.
6.3 (B) 7. e.	assessing performance relative to provider improvement goals; and		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and the MCO and providers review the available data and discuss performance relative to goals during each interaction pursuant to Section 6.3(B) 7 c, above and at least one provider achieves measurable improvement each calendar year.
6.3 (B) 7. f.	motivating and supporting high-volume provider efforts to generate quality improvement through the use of provider incentives and the provision of resources to assist providers in improving performance. *Clarification: Provider incentives and resources may be financial, in-kind contributions or non-financial in nature. For example, "incentives" could be performance improvement or shared savings arrangements, or recognition of superior performance in MCO provider directories. "Resources" could include training materials or programs on the use of and/or funding for patient registries and practice-based care managers.*		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and fully participates in each Blueprint for Health roll-out within the state.

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6.3 (B) 8.	In order to assist providers who do not meet managed care organization quality standards, at least annually measure the performance of high volume contracted providers and: *Clarification: Compliance with requirements 6.3 (B) 8. a-f may, in part, address requirement 6.3 (D).* **Deeming opportunity**: MCO participates in Blueprint for Health as described in D.S. Bennett's October 22, 2014 memo (see Appendix I). This applies to 6.3(B)8.a-f.		
6.3 (B) 8.a.	adopt and publish quality standards for primary care physicians, specialists (including mental health care providers) and hospitals; *Clarification:* • *Quality standards represent minimum quality performance expectations below which the MCO expects providers should not fall.* • *Quality standards could include the Joint Commission's hospital accreditation standards, specific HEDIS measures or specific practice guidelines or other criteria. MCOs may use the CMS hospital accreditation survey to satisfy hospital compliance requirements regarding the Joint Commission's standards.* • *For now, the Department will continue to conditionally deem the practices selected for the Common Physician Measurement project as meeting this requirement with respect to specialists for Managed Mental Health Organizations.*		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
		To meet this requirement, the MCO must adopt and publish quality standards for: primary care physicians, at least two types of specialists, acute care hospitals and mental health and substance abuse hospitals	The MCO meets the requirement and adopts and publishes quality standards for at least four types of specialists (which could include ancillary services providers)[18].
6.3 (B) 8.b.	measure and report results to providers;		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and presents provider performance relative to the standard and to other contracted providers or an external benchmark.
6.3 (B) 8.c.	identify providers, provider sites and/or provider practices that do not meet the managed care organization's standards;		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and identifies for the provider potential steps for the provider to achieve compliance with MCO quality standards.

[18] Ancillary services providers are health care providers who deliver services to members of MCOs, but are not physicians, hospitals, or any other health care facilities. Some ancillary providers include physical, respiratory, and occupational therapists, chiropractors, durable medical equipment companies, pharmacies and medical transportation companies.

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6.3 (B) 8.d.	take appropriate action to correct deficiencies, including establishing corrective action plans with providers;		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and the corrective action plan includes a) actions to be taken by the provider, b) timelines, and c) expectations for improved performance levels.
6.3 (B) 8.e.	monitor providers to determine where they have implemented corrective action; and		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and increases the frequency of required practice submissions to at least twice per year, if the initial corrective action results suggest continued difficulty in achieving MCO quality standards.
6.3 (B) 8. f.	take appropriate and significant action when a provider has not implemented corrective action, including but not limited to requesting the credentialing verification committee to initiate a review of the provider's performance. *Clarification: To meet this requirement, the MCO must demonstrate that its credentialing committee takes timely and appropriate action based on performance data that documents performance that falls below MCO-defined thresholds, when a provider has not implemented corrective action.*		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			N/A
6.3 (B) 9.	Maximize the number of members receiving care consistent with treatment protocols and practices that are informed by generally accepted medical and scientific evidence and practice parameters consistent with prevailing standards of medical practice as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition, and that are developed with the appropriate clinical input. The managed care organization shall review the protocols and practices at least once every two (2) calendar years, or more often if practice standards change; and employ substantive incentives for contracted providers to improve their adherence to accepted protocols and practices. **Deeming Opportunity:** MCO fully meets NCQA HP QI 9 and employs substantive incentives for contracted providers to improve their adherence to accepted protocols and practices.		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and has implemented a pay-for-performance program or other performance incentive-based program focused on evidence-based care metrics that has been formally evaluated and shown to increase provider compliance with evidence-based protocols.

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6.3 (B) 10.	If indicated, improve access to care for members according to travel and waiting time standards established in this rule by developing policies to support travel and waiting time standards, disseminating waiting time standards to providers, at least annually assessing waiting times for services, reporting findings to contracted providers, and taking action to improve access where indicated by the assessment of waiting times for services; **Deeming Opportunity:** MCO fully meets NCQA HP QI 5 and disseminates waiting time standard to providers, and reports findings to contracted providers, and takes action to improve access where indicated by the assessment of waiting times for services.		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and demonstrates sustained, measureable improvement in deficient areas of access over the most recent two-year period of time or collaborates with other MCOs or health care provider groups to develop and implement an action plan to improve access.
6.3 (B) 11.	Promote the use of preventive health services by: a. Adopting practice guidelines specific to preventive health services that are based on reasonable medical evidence; and b. Establishing effective procedures for informing members on at least an annual basis about preventive health services available to them;		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and has implemented incentive programs to reward members for obtaining appropriate preventive health services.
6.3 (B) 12.	Inform members in hard copy, on the internet, or in an electronic mailing, at least annually, about health promotion programs available to them, such as smoking cessation courses, nutritional courses, and weight loss programs; and		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and provides financial and/or non-financial incentives to members who enroll in and complete health promotion programs that are designed to reduce members' identified health risks.
6.3 (B) 13.	Conduct an annual quality management program evaluation that includes an evaluation of the effectiveness of the strategies implemented in paragraph 4 of this subsection. **Deeming Opportunity:** MCO fully meets NCQA HP QI, 1, Element B.		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and has used the evaluation to modify its quality improvement initiatives in its most recent quality management work plan (see 6.3(C)).

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6.3 (C)	Each managed care organization shall develop an annual quality management work plan containing a written description of clinical and administrative quality improvement activities, including improvement goals and attendant measures, project timelines, accountable persons, data collection activities and how the activities meet objectives of the quality management program. The quality management work plan will also clearly identify quality improvement goals agreed upon with the Department (or, at the discretion of the Department, selected by the managed care organization) and reported to the Department under Section 6.4(B). **Deeming opportunity**: MCO participates in Blueprint for Health as described in D.S. Bennett's October 22, 2014 memo (see Appendix I).		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement <u>and</u> the work plan includes goals integrating mental health and substance abuse services with other health care, and supports Blueprint for Health-participating practices.
6.3 (D) 1.	By January 1, 2010, each managed care organization shall have established participation in at least two (2) joint quality improvement projects with one (1) or more other managed care organizations. This requirement differs from and is in addition to joint quality improvement projects between a health insurer and a managed care organization or mental health review agent that manages the mental health benefits for the health insurer's health benefit plan, including the project required in Subsection 6.4(C). <u>Clarification</u>: *Managed Mental Health Care Organizations are required to establish participation in one joint quality improvement project in 2011, and are required to establish participation in two joint quality improvement projects in 2012.* **Deeming opportunity**: MCO participates in Blueprint for Health as described in D.S. Bennett's October 22, 2014 memo (see Appendix I).		
	1 = Does not meet	**2 = Meets**	**Exceeds**
			N/A
6.3 (D) 2.	Each managed care organization shall include the joint projects in its annual quality improvement work plan filed with the Department in 2010; shall implement the projects during calendar year 2010; and shall thereafter include at least two (2) joint projects in its annual quality improvement work plan and continue to participate in at least two (2) joint quality improvement projects on an ongoing basis, subject to Subsection 3 of this section. The Commissioner, in her or his sole discretion, may determine whether a joint quality improvement project meets the requirements of this section. **Deeming opportunity**: MCO participates in Blueprint for Health as described in D.S. Bennett's October 22, 2014 memo (see Appendix I).		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**

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			The MCO meets the requirement and actively involves providers in the planning and implementation of each project, and, if one or both projects have been implemented for at least two years, the project(s) have produced statistically significant positive results in the past two years.
6.3 (D) 4.	In addition, managed care organizations shall actively participate in quality improvement initiatives aimed at improving public health that are sponsored by the Department of Health, Agency of Human Services, Agency of Administration and/or other State agencies. Managed care organizations shall also cooperate with the Department and its quality improvement contractors in conducting clinically-focused studies, developing clinical practice guidelines, participating in joint quality improvement activities, and/or consistently attending Department meetings, when invited. **Deeming opportunity**: MCO participates in Blueprint for Health as described in D.S. Bennett's October 22, 2014 memo (see Appendix I).		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and demonstrates significant initiative and leadership in its cooperation with the Department and its quality improvement contractors in conducting clinically-focused studies, developing clinical practice guidelines, and/or participating in joint quality improvement activities.

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6.3 (F)	At least once every three (3) years after the initial verification of credentials, during recredentialing of contracted providers, each managed care organization shall conduct a performance appraisal of high volume primary care providers and specialists, to include a review of • member complaints, • clinical quality performance, and • efficiency data[19] specific to the provider. Alternatively, the managed care organization may conduct such performance appraisal between recredentialing cycles and, if issues are identified, demonstrate that the issues are brought to the attention of the managed care organization's credentialing committee for review and action. The managed care organization shall adjust for provider case mix when evaluating efficiency data. Such a performance appraisal shall include a comparison of the provider's performance against quantitative thresholds established by the managed care organization representing managed care organization standards that have been communicated to contracted providers in advance of the performance appraisal period. If the credentialing committee determines that an action that will negatively affect a provider's contracted status is warranted and the determination is based on the components of the performance appraisal that were derived from claims data, the managed care organization shall confirm those results with a review of medical records prior to taking action if requested by the provider. *Clarification: If an MCO conducts performance appraisals of high-volume PCPs, OB/GYNs and mental health/substance abuse providers, and brings issues from such appraisals to the attention of the MCO's credentialing committee for review and action as they are identified, the Department will consider the MCO to meet the requirements for conducting and using such appraisals for high volume primary care providers and specialists, as required in Section 6.3(F).*		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			The MCO meets the requirement and the performance review includes four or more statistical clinical quality indicators for each provider specialty, gathered either on an individual MCO basis or jointly with other MCOs.

[19] Efficiency indicators include, for example, relative resource use indicators or resources used to treat a commonly defined condition or to perform a commonly defined procedure and related services.

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6.3 (G)	Each managed care organization shall engage in quality improvement activities that result in improvements in the quality of care and service provided to the managed care organization's Vermont members as compared to the managed care organization's performance from immediately preceding years. Quality of care shall be evaluated by using measures that have been developed, adopted or deemed appropriate for quality measurement by national organizations with recognized expertise in quality measurement, such as the National Committee for Quality Assurance (NCQA), the National Quality Forum, the Centers for Medicare and Medicaid Services and the Ambulatory Quality Alliance, and that are annually filed with the Department pursuant to Section 6.6. Areas to be evaluated by the Department for improvement include: *<u>Clarification</u>: In instances in which NCQA utilizes both individual and composite measures, compliance will be assessed using the individual measures only, and not the composite measures.*		
6.3 (G) 1.	member service, satisfaction and experience of care;		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
		The MCO generated statistically significant improvement on at least one CAHPS MCO administrative service measure, satisfaction measure, or experience of care measures in its most recent data submission under Section 6.6(B)11.	The MCO meets the requirement <u>and</u> attained performance levels that were statistically significantly above the national benchmark for at least 75% of the Department-specified CAHPS administrative service, satisfaction and experience of care measures <u>or</u> that were statistically significantly above the New England benchmark for at least 50% of the same measures in its most recent data submission under Section 6.6(B)11.
6.3 (G) 2.	preventive care;		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
		The MCO generated statistically significant improvement on at least one HEDIS Effectiveness of Care preventive measure in its most recent data submission under Section 6.6(B).	The MCO meets the requirements <u>and</u> attained performance levels that were statistically significantly above the national benchmark for at least 75% of the Department-specified HEDIS Effectiveness of Care preventive measures <u>or</u> that were statistically significantly above the New England benchmark for at least 50% of the same measures in its most recent data submission under Section 6.6(B).
6.3 (G) 3.	acute illness care; and		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**

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		The MCO generated statistically significant improvement on at least one HEDIS Effectiveness of Care acute illness care measure in its most recent data submission under Section 6.6(B).	The MCO meets the requirement and attained performance levels that were statistically significantly above the national benchmark for at least 75% of the Department-specified HEDIS Effectiveness of Care acute illness care measures or that were statistically significantly above the New England benchmark for at least 50% of the same measures in its most recent data submission under Section 6.6(B).
6.3 (G) 4.	chronic illness care.		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
		To meet this requirement the MCO generated statistically significant improvement for at least two HEDIS Effectiveness of Care chronic illness care measures in its most recent data submission under section 6.6(B).	The MCO meets the requirements and attained performance levels that were statistically significantly above the national benchmark for at least 75% of Department-specified HEDIS Effectiveness of Care chronic illness care measures or that were statistically significantly above the New England benchmark for at least 50% of the same measures in its most recent data submission under Section 6.6(B).
6.4 6.4 (A)	Annual Quality Improvement Goals The managed care organization shall annually identify quality improvement goals and associated projects being pursued for Vermont members contained in the annual quality management work plan required by Section 6.3(C) of this rule, and shall define quantitative metrics to assess goal attainment in accordance with guidance established by the Department. The goals and associated projects shall be negotiated with the Department. The Department may, in its sole discretion, allow a managed care organization to select its own quality improvement goals and associated projects through an alternative quality improvement goal process if the Department determines that the managed care organization has demonstrated the ability to select goals and associated projects that meet the requirements of this rule. The quality improvement goals shall be based on opportunities for improvement identified through:		
6.4 (A) 1.	the Department's evaluation of the annual filing referenced in Section 6.6(B) of this rule;		
6.4 (A) 2.	the managed care organization's evaluation of the quality of care provided to its members; and		
6.4 (A) 3.	other appropriate sources of data regarding health care quality.		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			N/A
6.4 (B)	The managed care organization shall provide progress reports to the Department on the quality improvement goals semi-annually or annually if the managed care organization is determined to be eligible for the alternative quality improvement goal process described in Subsection 6.4(A) of this rule. The Department shall evaluate the managed care organization's quality improvement goals using one (1) or more of the following criteria:		
6.4 (B) 1.	whether the goals are of adequate breadth in terms of the number and degree of difficulty of the goal activities and interventions;		
6.4 (B) 2.	whether the managed care organization made a good faith effort to achieve each goal; and		
6.4 (B) 3.	whether improvement has been achieved.		

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	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
		The MCO provided semi-annual progress reports (or annual if eligible for the alternative quality improvement goal process) and the performance relative to the goals met the criteria employed by the Dept., i.e., one or more of 6.4(B)1-3.	The MCO meets the requirement <u>and</u> the MCO's year-end performance meaningfully exceeds the goals.
6.4 (C)	When a health insurer contracts with another managed care organization or a mental health review agent to manage the mental health benefits for a health benefit plan subject to this Part, a minimum of one (1) of the quality improvement projects to be completed annually shall be a joint project between the health insurer and the managed care organization or mental health review agent that manages the mental health benefits. The project shall be reported to the Department under Section 6.4(B). The project shall implement policies and incentives to increase collaboration among providers, with the goal of facilitating clinical integration of services for medical and mental health conditions. The project shall:		
6.4 (C) 1.	include evidence of how data collected from the project are being used to inform the practices, policies, and future direction of care management programs for mental health conditions; and		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			N/A
6.4 (C) 2.	demonstrate how the project is supporting the incorporation of best practices and evidence-based guidelines into the utilization review of mental health conditions.		
	1 = Does not meet	**2 = Meets**	**3 = Exceeds**
			N/A
6.5 6.5 (A)	<u>Chronic Care Program Requirements.</u> Each managed care organization shall develop and maintain a program under the direction of its medical director that is designed to assist its members and their providers in managing chronic conditions in a way that will improve the health status of members who have chronic conditions. If a managed care organization participates in the blueprint for health chronic care initiative, it is deemed to meet the requirements of this section for those geographic areas in which the blueprint for health is active. The Department, in its sole discretion, may determine that the managed care organization is deemed to meet the requirements of this section for the entire state if the managed care organization is participating in the blueprint for health in communities covering a majority of the state's population. **Deeming Opportunity**: The MCO is fully accredited by URAC in Disease Management Version 3.0 and Case Management Version 4.0.		
	1 = Does not meet		**2 = Meets**

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6.5 (B)	The managed care organization's program may use the managed care organization's own personnel, or program resources may be provided through a contracted organization. The managed care organization may also elect to support physician practices and/or community care teams that are participating in the blueprint for health in implementing the chronic care program. When such support and implementation occurs, the Department in its sole discretion may determine that certain requirements in this Section 6.5 are not applicable to the managed care organization.	
	1 = Does not meet	**2 = Meets**
6.5 (C)	In developing and maintaining its chronic care program, each managed care organization shall:	
6.5 (C) 1.	identify the prevalence of the chronic conditions that have, or will have, the greatest impact on the health status of the managed care organization's population and focus particular attention on these when developing its chronic care program and services;	
	1 = Does not meet	**2 = Meets**
6.5 (C) 2.	recognize that a high percentage of members have more than one chronic condition, and focus on supporting members and health care providers in safely and effectively managing multiple chronic conditions; **Deeming Opportunity:** MCO fully meets NCQA HP QI 8, and supports health care providers in safely and effectively managing multiple chronic conditions.	
	1 = Does not meet	**2 = Meets**
6.5 (C) 3.	ensure that chronic care program activities are coordinated between and among the patient's treating health care providers and case managers, including those providers and case managers addressing mental health and substance abuse issues, unless prohibited by law; and **Deeming Opportunity:** MCO fully meets NCQA HP QI 8, HP QI 10 and QI 11.	
	1 = Does not meet	**2 = Meets**
6.5 (C) 4.	design the program to accommodate the potential impact of program activities on members with mental health conditions including substance abuse conditions or disorders.	
	1 = Does not meet	**2 = Meets**
6.5 (D) (1) through (6)	The managed care organization shall systematically and at least monthly identify members who have, or who are at risk for developing, chronic conditions, using the following data sources: • Claims or encounter data; • Pharmacy data, if applicable; • Health risk appraisal results; • Laboratory results, if applicable; • Data collected through the UM or case management process, if applicable; and • Member and provider referrals. **Deeming Opportunity:** MCO fully meets NCQA HP QI 8, Element B and identifies members on a monthly basis.	
	1 = Does not meet	**2 = Meets**

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6.5 (E) 6.5 (E) 1.	The program shall: have a mechanism to assess the accuracy of case finding prior to initiating contact with the member;	
	1 = Does not meet	**2 = Meets**
6.5 (E) 2.	initiate contact with members in writing and: a. Convey clear information regarding the financial or other benefits/consequences of the choice to participate or decline; b. Disclose the qualifications of program staff; c. Explain how the patient's provider will be involved; and d. Elicit the member's preference regarding telephone contacts and messages.	
	1 = Does not meet	**2 = Meets**
6.5 (E) 3.	support condition monitoring by the member and the health care provider; **Deeming Opportunity:** MCO fully meets NCQA QI 8, Element A.	
	1 = Does not meet	**2 = Meets**
6.5 (E) 4.	maximize member participation in and engagement with the chronic care program and with self-management;	
	1 = Does not meet	**2 = Meets**
6.5 (E) 5.	consider and modify the managed care organization's chronic care support services as needed in response to a member's multiple health conditions; and	
	1 = Does not meet	**2 = Meets**
6.5 (E) 6.	address member lifestyle issues, as indicated by practice guidelines, and also address environmental issues (e.g. – characteristics of home and work settings). **Deeming Opportunity:** MCO fully meets NCQA QI 8, Element A.	
	1 = Does not meet	**2 = Meets**
6.5 (F)	The managed care organization shall provide members with written chronic care program information regarding:	
6.5 (F) 1.	how members become eligible to participate;	
6.5 (F) 2. 6.5 (F) 3.	how members use the services; and how members may participate in the chronic care program, and opt in or opt out of the chronic care support services offered by the managed care organization. **Deeming Opportunity:** MCO fully meets NCQA QI 8, Element D.	
	1 = Does not meet	**2 = Meets**
6.5 (G)	The managed care organization shall provide the most appropriate interventions after stratifying members based on the severity of risk that each member faces and/or the member's assessed readiness to change his or her behaviors. **Deeming Opportunity:** MCO fully meets NCQA QI 8, Element E.	
	1 = Does not meet	**2 = Meets**

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6.5 (H) 6.5 (H) 1.	The managed care organization shall provide: all members with information regarding community-based self-management support and self-management education resources available to members.	
	1 = Does not meet	**2 = Meets**
6.5 (H) 2.	The managed care organization shall provide: all members participating in chronic care programs with:	
6.5 (H) 2. a.	opportunities for office or telephone visits, group meetings and/or written communication for the purpose of action planning, problem solving and other active involvement in the development and ongoing enhancement of their self-management plans. At the discretion of and with the consent of the member, these activities may be implemented by and with any or all of the following:	
6.5 (H) 2. a. i.	qualified members of the primary care provider's practice, including the primary care provider, the practice's care manager, and the practice's care coordinator;	
6.5 (H) 2.a. ii.	a Blueprint Community Care Team care manager, if available;	
6.5 (H)2.a. iii.	a managed care organization care manager or care coordinator;	
	1 = Does not meet	**2 = Meets**
6.5 (H) 2. b.	ongoing self-management education and self-management support to develop and enhance the member's self-management skills; and	
	1 = Does not meet	**2 = Meets**
6.5 (H) 2. c.	processes and tools to track adherence to the member's self-management plan. <u>Clarification:</u> *The MCO may partially meet the requirements of 6.5(H) by having its case managers encourage and confirm member participation in local Vermont Healthier Living Workshops, where available.*	
	1 = Does not meet	**2 = Meets**
6.5 (I)	The managed care organization shall integrate information from the following systems to facilitate access to member health information for continuity of care:	
6.5 (I) 1.	a health information line or web-based health information resource;	
6.5 (I) 2.	a disease management program;	
6.5 (I) 3.	a case management program; and	
6.5 (I) 4.	a utilization management program, if applicable. **Deeming Opportunity:** MCO fully meets NCQA HP QI 8, Element H.	
	1 = Does not meet	**2 = Meets**
6.5 (J)	The managed care organization shall provide written chronic care program information to providers regarding:	
6.5 (J) 1.	instructions on how to access, use, and coordinate with the managed care organization's chronic care program and services; and **Deeming Opportunity:** MCO fully meets NCQA HP QI 8, Element G.	
	1 = Does not meet	**2 = Meets**

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6.5 (J) 2.	how the chronic care program and services work with the health care provider's patients in the program. **Deeming Opportunity:** MCO fully meets NCQA HP QI 8, Element G.	
	1 = Does not meet	**2 = Meets**
6.5 (K) 1.	The managed care organization shall assist, support and provide incentives to all contracted primary care practices to better manage chronic conditions by: offering access to provider and practice-specific patient-level data and reports that will aid them in their efforts to provide good chronic care, such as patients admitted to or discharged from inpatient care, patients who have and have not received recommended outpatient care;	
	1 = Does not meet	**2 = Meets**
6.5 (K) 2.	Providing information regarding community-based self-management support and education resources available to members and providers;	
	1 = Does not meet	**2 = Meets**
6.5 (K) 3.	Offering tools to track adherence by the member to the member's self-management plan;	
	1 = Does not meet	**2 = Meets**
6.5 (K) 4.	Motivating and supporting primary care providers in:	
6.5 (K) 4. a.	using office-based information systems that support chronic care, such as electronic registries;	
	1 = Does not meet	**2 = Meets**
6.5 (K) 4. b.	providing team-based care by primary care providers;	
	1 = Does not meet	**2 = Meets**
6.5 (K) 4. c.	providing services that support chronic care management, but have not historically been covered;	
	1 = Does not meet	**2 = Meets**
6.5 (K) 4. d.	conforming with evidence-based guidelines for chronic care;	
	1 = Does not meet	**2 = Meets**
6.5 (K) 4. e.	integrating a care coordination/care management function within the primary care practice; and	
	1 = Does not meet	**2 = Meets**
6.5 (K) 4. f.	obtaining recognition through formal programs that encourage the use of team-based, systematic, patient-centered, coordinated care management processes such as the Physician Practice Connections® – Patient-Centered Medical Home™ program of the National Committee for Quality Assurance.	
	1 = Does not meet	**2 = Meets**
6.5 (L)	The managed care organization shall use the following mechanisms to assess the effectiveness of the chronic care program:	
6.5 (L) 1.	Annual measurement of member participation rates; **Deeming Opportunity:** MCO fully meets NCQA HP QI 8, Element F.	
	1 = Does not meet	**2 = Meets**
6.5 (L) 2.	Annual measurement of the effectiveness of the chronic care program. Each measurement shall:	

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6.5 (L) 2. a.	address a relevant process and outcome;	
6.5 (L) 2. b.	produce a quantitative result;	
6.5 (L) 2. c.	be population-based;	
6.5 (L) 2. d.	use data and methodology that are valid for the process or outcome being measured; and	
6.5 (L) 2. e.	be analyzed in comparison to an established benchmark or goal; **Deeming Opportunity:** MCO fully meets NCQA HP QI 8, Element J.	
	1 = Does not meet	**2 = Meets**
6.5 (L) 3.	Annual evaluation of perceptions of and satisfaction with its chronic care program among members who participate as well those who opt out of the chronic care support services offered by the managed care organization; and **Deeming Opportunity:** MCO fully meets NCQA HP QI 8, Element I and includes those who have opted out of participation in its evaluation.	
	1 = Does not meet	**2 = Meets**
6.5 (L) 4.	Annual evaluation of contracted health care providers' perceptions of and satisfaction with its chronic care program.	
	1 = Does not meet	**2 = Meets**
6.6 (B)	Annual Filing Requirement: Each managed care organization shall file a copy of its quality improvement work plan prepared pursuant to the requirements of this rule on an annual basis on or before March 31st or another date as determined by the Commissioner. Each managed care organization shall file the following performance and other information in accordance with the Department's specifications on an annual basis, on or before July 15th or another date as determined by the Commissioner. The Department may impose these annual filing requirements on a more frequent basis as it determines is warranted: *Clarification: See Appendix A for details of annual filing requirements.* **Deeming Opportunity:** MCO fully meets NCQA HP QI 1, Element B, and includes within its quality improvement work plan a written description of clinical and administrative quality improvement activities including: attendant measures, data collection activities, and how the data collection activities meet the objectives of the quality management program, and has been approved by the Department to participate in the annual alternative goal process described in the Implementation Manual. This does not however preclude the filing, annually on March 31, of a description of the MCO's joint or individual quality improvement goals for which it intends to report progress at year-end to the Department.	
6.6 (B) 16.	Material changes to policies, procedures, member communications, provider contracts or any other documents required by this rule. *Clarification: Material changes include those regarding the MCO's development of a new relationship with an entity to which it has delegated responsibility for one or more Rule H-2009-03 regulated functions or processes, or the expansion, contraction or termination of a delegation arrangement with an existing delegated entity. The MCO shall inform the Department of such changes in advance of their implementation.*	
	1 = Does not meet	**2 = Meets**

APPENDICES

Table of Contents

Appendix A

Specifications for the Annual Rule 9-03 Data Filings

Appendix A is designed to assist Managed Care Organizations (MCOs) in preparing the July 15th data filings required under Vermont Rule H-2003-09 ("Rule 9-03"). This appendix contains instructions for this filing, as well as copies of forms and checklists designed to assist MCOs in assuring that all filing requirements are met.

In addition, MCOs are also required to submit joint quality improvement goals as outlined in 6.3(D).

Reporting requirements for July 15th are specified in Section 6.6(B)(1) through (15) of Rule H-2009-03. These reporting requirements are explained in the remainder of Appendix A and are organized by type and source of data, i.e., HEDIS®, CAHPS®, and Rule 9-03-specific measurement requirements. Data submission tables developed by the Department for use by the MCOs are available as Excel spreadsheets.

Two checklists are also available at the end of Appendix A to further assist MCOs in preparing the July 15th data filing; one for Managed Mental Health Care Organizations and one for Managed Non-Mental Health Care Organizations.

A. HEDIS® Data Filing

HEDIS data submissions are required to meet the filing requirements specified in the following sections of Rule H-2009-03:

- 6.6(B)2
- 6.6(B)3
- 6.6(B)5
- 6.6(B)9
- 6.6(B)13

The Department's filing requirements are updated annually and track with the changes published in the most current NCQA HEDIS® Volume 2: Technical Specifications. The Department's requirements also reflect NCQA's annual rotation of reported measures. NCQA typically finalizes HEDIS® measures in October of each year. MCOs must submit HEDIS® data for their Vermont members only.

HEDIS® data may be filed using either the tables included in Appendix A or the NCQA IDSS report (exported into Excel), so long as the measures are based on Vermont member data only and include all required information. HEDIS RRU® measures must be reported in an XML format.

As of 2010, Managed Mental Health Care Organizations are required to submit only the following HEDIS® measure:

- Mental Health Utilization - % of members receiving any services, inpatient, intensive outpatient or partial hospitalization, and outpatient or ED services

All MCOs must provide verification that NCQA specifications were followed by submitting one of the following:

- HEDIS Compliance Audit;
- attestation from vendor, or
- vendor certification from NCQA.

The table on the following page lists the HEDIS® measures required for the next July 15 data filing. This table may be used as a checklist to assist in preparing an MCO's filing. The listing of required HEDIS® measures is repeated within the checklist at the end of this appendix. A copy of the checklist **must be submitted,** identifying each submitted data item, as part of the MCO's July data filing.

HEDIS® Measures for July 15, 2015
Effectiveness of Care Measures:
Table HPV 1/2: Human Papillomavirus Vaccine for Female Adults
Table BCS-1/2/3: Breast Cancer Screening
Table CCS-1/2: Cervical Cancer Screening
Table NCS-1/2: Non-Recommended Cervical Cancer Screening in Adolescent Females
Table CHL-1/2: Chlamydia Screening in Women
Table CWP-1/2: Appropriate Testing for Children with Pharyngitis
Table URI-1/2: Appropriate Treatment for Children with Upper Respiratory Infection
Table AAB-1/2: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
Table PCE-1/2/3: Pharmacotherapy Management of COPD Exacerbation
Table ASM-1/2/3: Use of Appropriate Medications for People with Asthma
Table MMA-1/2: Medication Management for People with Asthma
Table AMR – 1/2: Asthma Medication Ratio
Table CBP-1/2/3: Controlling High Blood Pressure
Table BPH-1/2/3: Persistence of Beta-Blocker Treatment after a Heart Attack
Table CDC-1/2/3: Comprehensive Diabetes Care
Table ART-1/2/3: Disease Modifying Anti-Rheumatic Drug Therapy for RA
Table LBP-1/2: Use of Imaging Studies for Low Back Pain
Table AMM-1/2/3: Antidepressant Medication Management
Table ADD-1/2: Follow-up Care for Children Prescribed ADHD Medication
Table FUH-1/2/3: Follow-up After Hospitalization for Mental Illness
Table APC-1/2: Use of Multiple Concurrent Antipsychotics in Children and Adolescents
Table APM-1/2: Metabolic Monitoring for Children and Adolescents on Antipsychotics
Table MPM-1/2/3: Annual Monitoring for Patients on Persistent Medications
Aspirin Use and Discussion (ASP) (2-year rolling average--CAHPS)
Medical Assistance with Smoking and Tobacco Use Cessation (MSC) (2-year rolling average--CAHPS)
Flu Vaccinations for Adults Ages 18–64 (FVA)
Access/Availability of Care:
Table AAP-1/2/3: Adults' Access to Preventive/Ambulatory Health Services
Table CAP-1/2: Children's and Adolescents' Access to Primary Care Practitioners
Table IET-1/2/3: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Table PPC-1/2: Prenatal and Postpartum Care
Table CAT: Call Answer Timeliness
Table APP-1/2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
Use of Services:
Table W15-1/2/3: Well-Child Visits in the First 15 Months of Life
Table W34-1/2: Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
Table AWC-1/2: Adolescent Well-Care Visits
Table FSP-2: Frequency of Selected Procedures
Table AMB-2: Ambulatory Care
Table IPU-2: Inpatient Utilization General Hospital/Acute Care
Table IAD-2: Identification of Alcohol and Other Drug Services
Table MPT-2: Mental Health Utilization
Table ABX-1/2/3: Antibiotic Utilization
Table PCR-2/3 Plan All-Cause Readmissions
Relative Resource Use[20]:
Relative Resource Use for People with Diabetes (RDI)
Relative Resource Use for People with Asthma (RAS)
Relative Resource Use for People with Cardiovascular Conditions (RCA)
Relative Resource Use for People with Hypertension (RHY)
Relative Resource Use for People with COPD (RCO)
Health Plan Descriptive Information:
Table ENP-2: Member Months of Enrollment by Age and Sex (Specify Product)

[20] For 2011 NCQA changed the method for reporting Relative Resource Measures and required the submission of XML data through the IDSS and no longer provides a visual presentation of the data. As such the Department cannot provide Excel tables for this submission. MCOs should provide RRU data in XML format to NCQA.

B. CAHPS® Data Filing

CAHPS® data submissions are required to meet the filing requirements specified in Section 6.6(B)11 of Rule H-2009-03:

All Managed Non-Mental Health Care Organizations must file the results of the CAHPS® Health Plan Survey, 5.0H Adult Version and report survey results for Vermont members only.

The CAHPS® survey must have been administered during the year in which it is submitted to the Department as part of the annual data filing requirements. The survey must be administered by an NCQA-certified vendor according to the most current NCQA CAHPS® survey administration and reporting protocols. Each MCO must include with its filings any one of the following three documents as evidence that this requirement has been met:

- a document from its NCQA-certified vendor attesting that in administering the surveys it followed NCQA specifications for sample selection, survey administration and data analysis;
- a certificate from NCQA certifying the vendor to be an NCQA-approved vendor, or
- a copy of the NCQA compliance audit.

MCOs may submit their results using tables included in this appendix or using NCQA banner tables. If banner tables are used, the submission must include each of the data items specified in the tables for each of the required questions.

The Department has provided the following four tables to assist MCOs in reporting CAHPS® results:

- CAHPS® Table 1: Demographics
- CAHPS® Table 2: Overall Ratings
- CAHPS® Table 3: Composite Table
- CAHPS® Table 4: Care Management Questions Table

These four tables are available as Excel spreadsheets.

C. Utilization Review Decisions Data Filing

Utilization review data submissions are required to meet the filing requirements specified in Section 6.6(B)8 of Rule 9-03.

UR data shall be submitted for dates covering the prior calendar year; that is, for a July 2015 submission, UR data must cover calendar year 2014.

The following UR categories provide the decision timeframes within which review decisions must be made to be in compliance with Rule 9-03. *Please note that urgent and non-urgent pre-service request timeframes were changed by statute in 2013 [Sec. 5a 18 V.S.A. § 9418b(g)(4)] to reflect the timeframes shown below*.

UR Requests Categories	**Rule 9-03 Timeframe**
Urgent Concurrent Review Received > 24 Hours Prior	≤ 24 Hours
Urgent Concurrent Review Received < 24 Hours Prior	≤ 24 Hours
Urgent Pre-service Review	≤ 48 Hours
Non-Urgent Pre-Service Review	≤ 2 Business Days
Post Service Review	≤ 30 Days

Reporting must be done in terms of calendar days, except as noted.

In calculating UR timeframes, MCOs should consider the following clarifications:

1. **Pre-service urgent review requests**
   MCOs shall respond to a completed urgent pre-service request from a health care provider within 48 hours to make a decision. The MCO shall notify a health care provider of or make available to a health care provider a receipt of the request for prior authorization and any needed missing information within 24 hours of receipt. If an MCO does not, within the time limits set forth, respond to a completed prior authorization request, acknowledge receipt of the information or request missing information, the prior authorization request shall be deemed to have been granted.

2. **Pre-service non-urgent review requests**
   MCOs respond to a completed pre-service request from a health care provider within two (2) business days of receipt for non-urgent requests. The MCO shall notify a health care provider of or make available to a health care provider a receipt of the request for prior authorization and any needed missing information within 24 hours of receipt. If an MCO does not, within the time limits set forth, respond to a completed prior authorization request, acknowledge receipt of the information or request missing information, the prior authorization request shall be deemed to have been granted.

3. **Post-service reviews**
   Section 3.2(F) allows the MCO a total of 30 days to render a decision under ordinary circumstances and 45 days if the MCO is facing circumstances beyond its control. As in Section 3.2(E), this section also requires MCOs to give members/providers at least 45 days to provide additional needed information. The decision time clock must stop at the time the member is notified of the need

for additional information and commences as soon as the information is received. For example, if an MCO tells a member on day 15 that additional information is needed, the MCO will have 30 days (15 days from the initial timeframe and a 15 day extension) to render a decision once the requested information is received.

4. **Sampling options**
   MCOs may report any or all of the four UR measures based on a randomly drawn sample or on the entire population of reviews. If using a sample, the sample size must be at least 60 denials within the category being measured. If during the reporting year the MCO had fewer than 60 denials within the category being measured, the MCO must report on the entire population of denials, and then randomly sample from approvals within the category being measured until the total number of reported reviews equals 60.

   Sampled reviews should include reviews conducted for both inpatient and outpatient services. The precise sampling methodology is left to the MCO's discretion providing that it results in the defined random sample as described above.

D. Grievance Review Data Filing

Grievance review data submissions are required to meet the filing requirements specified in Section 6.6(B)7 of Rule 9-03.

Grievance data shall be reported for the prior calendar year (January 1 – December 31).

Grievance tables and registries
To assist in the reporting of grievances the Department has developed the following three tables:

Table 2: Grievance Frequency and Outcome
Table 3: Grievance Resolution Process (days to make a decision from the date on which the grievance was received)
Table 4: Number and Percent of Grievances per Member

The types and levels of grievances that are to be reported are specified in Tables 2 and 3. There is no differentiation between physical health and mental health/substance abuse grievances for reporting purposes when the grievances are unrelated to an adverse benefit determination. Pharmacy grievances must be included in grievance reporting.

In addition to submitting the required grievance tables, MCOs are also required to submit grievance registers that contain the following information:

- unique identifying number;
- general description of grievance;
- date grievance received by MCO;
- dates of review and hearing;
- whether grievance was resolved at first level or required second level review;

- date all necessary information was received in event of extension, and
- grievance resolution & date of resolution.

Examples of Grievances

The following scenarios provide examples of the application of the definitions of grievance stated above. The scenarios are presented in no particular order.

	GRIEVANCE? YES OR NO	SCENARIO	REASON/GRIEVANCE TYPE
1	Yes	A member calls to request reconsideration of a denial of service because no PA was obtained.	Yes, because member is requesting reconsideration of a denial. ***(Grievance concerning service denials or coverage)***
2	No	A member calls to ask why services coverage was denied and learns that PA was required. Member accepts explanation.	Member did not request further recourse.
3	Yes	A member calls about a claim denial issue related to service coverage, and requests that the claim be covered.	Yes, further recourse is requested. ***(Grievance concerning service denials or coverage)***
4	Yes	A member calls to make a request for reconsideration of a decision to approve only a partial coverage of services requested. (Member does not know the reason for denial).	Yes, if MCO accepts oral grievances. Member requests plan recourse about a denial. ***(Grievance concerning service denials or coverage)***
5	No	A member calls to inquire why there was a claims payment denial and learns it was due to use of an unauthorized out-of-network provider. Member understands.	No recourse sought.
6	Yes	A member calls about a claim denial issue related to an error on the claim and requests that it be fixed. The MCO is unable to resolve the error during the call. In the same scenario, if the issue is resolved on the phone, it is not a grievance because no further recourse is sought after the initial call.	Yes, recourse sought. ***(Grievance Unrelated to an Adverse Benefit Determination: plan administrative performance)***
7	No	During a follow-up call about a claim denial issue, the MCO explains that the claim was paid erroneously due to MCO error, and the member expresses satisfaction with the result.	Member requests no further action.
8	Yes	During a follow-up call two months later when the MCO explains that the claim was paid erroneously due to MCO error, the member expresses dissatisfaction with how MCO handled this issue and how long it took to do so and wants recourse, e.g., member requests that his unhappiness be noted by the MCO and MCO staff manager be notified.	Yes, member requests further recourse. Date of receipt of grievance is date of this follow-up call to member. Time between initial member contact and resolution call is immaterial. Only the member's expression of dissatisfaction is material. ***(Grievance unrelated to an adverse benefit determination: plan administrative performance)***
9	No	Member calls to find out if specific services are covered, learns they are not. Member is not happy to hear this, but accepts the explanation.	Member did not ask for any further recourse.
10	Yes	Member calls to find out if specific services are covered, learns they are not. Member is not happy to hear this, and asks to pursue the MCO making an exception.	Yes, member seeks further recourse from the MCO. ***(Grievance concerning service denials or coverage)***
11	Yes	Member sends a letter expressing dissatisfaction that does not necessarily include the words "grievance" or "appeal."	Dissatisfaction expressed in writing. ***(Type of grievance will depend on letter content)***
12	No	Member calls CEO to express dissatisfaction, and issue is resolved between member and CEO (this could include CEO transferring call	CEO resolves or transfers call to member services where grievance calls are logged. Member services will handle it and will

	GRIEVANCE? YES OR NO	SCENARIO	REASON/GRIEVANCE TYPE
		to member services).	log it as a grievance if content warrants.
13	Yes	Member calls to express dissatisfaction about physician balance billing, but does not necessarily use the words, "grievance," "complaint" or "appeal. The member wants the MCO to contact the physician.	Yes, because member is seeking recourse. ***(Grievance unrelated to an adverse benefit determination: grievance about provider performance)***
14	Yes	Member calls to complain that member ID card has not arrived in the mail and wants to receive it.	Yes, member is seeking recourse. ***(Grievance unrelated to an adverse benefit determination: grievance about plan administration)***
15	No	MCO's sales rep is at a health fair and talks to a current member who says that she is thinking of switching to a new MCO because of problems around physician billing.	Member not seeking recourse from sales rep.
16	Yes	Member calls to complain about a provider's rude office staff. Member insists that the MCO registers the complaint.	Yes, member is seeking recourse. ***(Grievance unrelated to an adverse benefit determination: grievance about provider performance)***
17	Yes	Member writes to express anger at how long it took the MCO to address a concern about a claim error that resulted in an inappropriate denial.	Yes. ***(Grievance unrelated to an adverse benefit determination: grievance about plan performance)***
18	Yes	Member writes to request a reconsideration of a denial of a covered service she received out of network.	Yes. ***(Grievance about a service denial not requiring expedited review)***
19	Yes	Member writes to tell the MCO about how unhappy she is with the treatment she is receiving from her PCP and his office staff.	Yes. ***(Grievance unrelated to an adverse benefit determination: grievance about provider performance)***
20	Yes	Member writes to complain that there are too few choices of a particular specialty type provider in her geographic area.	Yes. ***(Grievance unrelated to an adverse benefit determination: grievance about access)***
21	Yes	Member calls to request an expedited review of a service denial.	Yes, oral expression of dissatisfaction is request for expedited review. ***(Grievance about a service denial requiring expedited review)***

E. Annual Filing of Provider Satisfaction Survey Data

Provider satisfaction survey data submissions are required to meet the filing requirements specified in Section 6.6(B)11 of Rule 9-03.

All MCOs must submit the results of an annual survey of network providers. Rule 9-03 requires that MCOs use a standardized state-approved survey instrument. The Department has approved and provided a core set of standard questions for provider satisfaction surveys. MCOs are expected to include at least this core set of standardized questions in their provider satisfaction surveys.

MCOs must also summarize any corrective actions taken based on the MCO's prior year provider satisfaction survey.

The provider satisfaction survey questions should be scored on a five point scale using the following responses:

- Strongly Agree
- Agree
- Neither Agree or Disagree
- Disagree
- Strongly Disagree

The Department-approved provider survey questions are:

1. Overall, I am satisfied with [MCO].
2. I would recommend [MCO] to other practitioners and to my patients.
3. [MCO's] staff is responsive when I need assistance.
4. [MCO's] quality of communications, such as care management tools, policy bulletins and manuals, is adequate.
5. [MCO] provides adequate support to patients with chronic conditions, or other serious illness.
6. [MCO's] prescription drug formulary is adequate.*
7. The amount of time spent obtaining [MCO] pre-approval for select prescription drugs is appropriate.*
8. The amount of time spent obtaining [MCO] pre-approval for services (other than prescription drugs) for my patients is appropriate.*
9. I have adequate access to [MCO's] Vermont utilization management department (e.g., when coverage for a service has been denied).
10. [MCO's] reimbursement levels are adequate.
11. [MCO's] claims payments are timely.
12. [MCO's] claims processing is accurate.
13. There are an adequate number and breadth of practitioners in [MCO's] network when I need to refer patients for other services.

* This question is not applicable to managed mental health care organizations. Managed mental health care organizations also do not need to include "(other than prescription drugs)" in Question #8 in their surveys.

F. Access: Travel Time Data Filing

Access data submissions, measured in terms of travel times to provider offices or facilities, are required to meet the filing requirements specified in Section 6.6(B)1 of Rule 9-03.

The travel time standards, detailed in Section 5.1(A) of Rule 9-03 are as follows:

Provider Type	**Travel Time Standard**
Primary Care Provider	30 minutes
Mental health/Substance Abuse (routine)	30 minutes
Outpatient specialty care	60 minutes
Intensive outpatient, partial hospitalization, residential or inpatient MH/SA services	60 minutes
Laboratory	60 minutes
Pharmacy	60 minutes
General optometry	60 minutes
Inpatient services	60 minutes
Imaging	60 minutes
Inpatient medical rehabilitation services	60 minutes
Kidney transplantation	90 minutes
Major trauma treatment	90 minutes
Neonatal intensive care	90 minutes
Tertiary-level cardiac services	90 minutes

The report shall include data on travel in terms of minutes, not mileage. When calculating travel time, the following assumptions regarding travel speed must be used: in urban areas – 25 mph; in suburban areas – 40 mph; in rural areas – 50 mph. These are the default values used by GeoAccess software to calculate travel times.

All geographic access reports for MCOs must be reported by county and at an aggregate state level. MCOs should not submit reports by town or zip code.

MCO are required to submit access reports on the following provider types annually:

Access within 30 minutes:

- Adult PCPs
- Pediatric PCPs
- Outpatient mental health and substance abuse services

MCOs should report any member up to their 20th birthday as a "child" for reporting requirements for adult and pediatric PCPs.

Access within 60 minutes:

- Outpatient physician specialty care (specific specialties rotate annually – see checklist for annual filing requirements)
- Intensive outpatient, partial hospital, residential or inpatient mental health and substance abuse services

MCOs are required to submit access reports on the following provider types on a rotating basis. The specific provider types are listed in the annual checklist update:

Access within 60 minutes:

- Laboratory
- Pharmacy
- General Optometry
- Inpatient
- Imaging
- Inpatient Medical Rehabilitation Services

Access within 90 minutes:

- Kidney Transplantation
- Major Trauma Treatment
- Neonatal Intensive Care
- Tertiary-Level Cardiac Services, including procedures such as cardiac catheterization and cardiac surgery

With respect to measures relative to travel to primary care services, MCOs must follow these guidelines:

- The report must include only primary care practices with open panels (i.e., practices are accepting new patients).

- MCOs must run separate reports for adult primary care and pediatric primary care providers.

- Measurement of adult primary care access must include internists and family practitioners and may include OB/GYNs, but only if they are actively serving MCO members in the capacity of a primary care provider.

- Measurement of pediatric care access should include pediatricians and family practitioners.

- MCOs must report information on network composition any time between April 1st and June 30th of the year in which the report is being filed.

- Health centers and clinics are not to be considered providers as part of the geographic access report. Instead, all individual practitioners, regardless of work location (e.g., private office, group practice, clinic), are to be included in the report.

With respect to travel time to outpatient mental health and substance abuse services, MCOs must:

- Report access to mental health and substance abuse services separately and also separately by provider type (e.g. inpatient, intensive outpatient/partial hospitalization, and outpatient/emergency department). HEDIS® definitions are to be used for all terms.

- Report by professional credentials for outpatient mental health services. Include master's level trained psychologists with other master's level trained professionals, such as licensed clinical social workers. Exclude ED facilities from this portion of the analysis.

- When reporting travel time to outpatient/ED mental health services, MCOs operating special integrated programs to serve dually diagnosed patients may report the programs serving this population in both the mental health and the substance abuse categories. This is also the case for other provider organizations that include both substance abuse and mental health treatment specialists on their staffs.

G. Access: Waiting Time Data Filing

Access data submissions, measured in terms of waiting times for provider services, are required to meet the filing requirements specified in Section 6.6(B)1 of Rule 9-03.

The waiting time standards, delineated in Rule 9-03, Section 5.1(B), are as follows:

Service Type	**Waiting Time Standard**
Emergency services	Immediately
Urgent care	24 hours
Non-emergency, non-urgent care	2 weeks
Preventive care	90 days

With respect to appointment waiting time, MCOs may elect to:

- use MCO-defined data collection methods for assessing performance against Rule 9-03 appointment wait time requirements, or

- sample their membership rather than report information for their entire membership, provided that the MCO provides a written description of the sampling methodology when submitting its survey results.

MCOs are required to report on the following categories for physical health care services:

- Emergency care;

- Urgent care;

- Non-emergency, non-urgent care, and

- Preventive care and routine physical examinations.

MCOs are required to report on the following categories for mental health/substance abuse services:

- Emergency care;

- Urgent care, and

- Non-emergency, non-urgent care.

Waiting time for mental health and substance abuse services must be distinguished and reported separately from waiting time for physical health care.

H. Current and Terminated Providers Data Filing

Data submissions regarding provider-initiated and plan-initiated terminations are required to meet the filing requirements specified in Section 6.6(B)10 of Rule 9-03.

MCOs must list all provider-initiated and plan-initiated terminations between January 1st and December 31st of the measurement year, keeping in mind that:

- Providers should not be considered "terminated" if they have died, retired or relocated.

- MCOs must group terminated contracts by MCO-defined categories of "reasons for termination" such as "documented quality problem" or "unwillingness to adhere to MCO UR and referral policies."

- The precise reason for termination must be indicated.

- The type of provider must be specified.

I. Provider Directories

Submission of provider directories is required to meet the filing requirements specified in Section 6.6(B)10 of Rule 9-03.

Provider directories may be submitted in electronic copy or a link to a website may be provided.

J. Delegated Functions

MCOs are required to submit information regarding delegated functions. Requirements are specified within Section 6.6(B)15 of Rule 9-03.

MCOs that delegate functions to contracted providers must submit information in Table 5: List of Delegated Functions.

K. Coordination and Continuity of Care Indicators

Data submissions regarding coordination and continuity of care indicators are required to meet the filing requirements specified in Section 6.6(B)4.

MCOs should submit data for the HEDIS® measure Plan All-Cause Readmissions (Table PCR – 2/3) to meet this requirement. This measure is included in the checklist under HEDIS® measures Use of Services.

L. Blueprint for Health Data Filing

MCO are required to submit data on specific measures to assess provider adoption and MCO support for Blueprint for Health concepts to meet Section 6.6(B)6 requirement of Rule 9-03:

1. Percent of contracted primary care providers (PCPs) receiving enhanced payment to support medical home operation.

    - The numerator for this measure is the number of contracted PCPs receiving enhanced payment to support medical home operations. The denominator for this measure is the total number of contracted PCPs in the network. The time period for this measure is January 1 through December 31 of the calendar year of the reporting period. MCOs are required to report this information in Table 6.

2. Per member per month (PMPM) value of enhanced practice payments to support medical home operation.

    - MCOs should report the total PMPM value of the enhanced practice payments they are making to support medical home operations. Total PMPM value should be calculated as the total enhanced practice payments over the total member months. The time period for this measure is January 1 through December 31 of the calendar year of the reporting period. MCOs are required to report this figure in Table 7.

3. Names and the percentage of Vermont Hospital Service Areas (VHSAs) where the MCO is making payments to support Community Health Teams in accordance with Vermont Blueprint-defined payment terms.

    - MCOs should indicate the Vermont Hospital Service Areas (VHSAs) to which they are making payments to support Community Health Teams in accordance with Vermont Blueprint-defined payment terms by putting a "Y" next to the relevant VHSA. They should then calculate what percentage of all Vermont HSAs is receiving such payments. The time period for this measure is January 1 through December 31 of the calendar year of the reporting period. MCOs are required to report this in Table 8.

CHECKLIST FOR MANAGED NON-MENTAL HEALTH CARE ORGANIZATIONS RULE 9-03 JULY 15TH DATA FILING		
HEDIS®	**Effectiveness of Care Measures:** ___ Table HPV 1/2: Human Papillomavirus Vaccine for Female Adults ___ Table BCS-1/2/3: Breast Cancer Screening ___ Table CCS-1/2: Cervical Cancer Screening ___ Table NCS-1/2: Non-Recommended Cervical Cancer Screening in Adolescent Females ___ Table COL-2/3: Colorectal Cancer Screening (COL) ___ Table CHL-1/2: Chlamydia Screening in Women ___ Table CWP-1/2: Appropriate Testing for Children with Pharyngitis ___ Table URI-1/2: Appropriate Treatment for Children with Upper Respiratory Infection ___ Table AAB-1/2: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis ___ Table PCE-1/2/3: Pharmacotherapy Management of COPD Exacerbation ___ Table ASM-1/2/3: Use of Appropriate Medications for People with Asthma ___ Table MMA-1/2: Medication Management for People with Asthma ___ Table AMR – 1/2: Asthma Medication Ratio ___ Table CBH-1/2/3: Controlling High Blood Pressure ___ Table BPH-1/2/3: Persistence of Beta-Blocker Treatment after a Heart Attack ___ Table CDC-1/2/3: Comprehensive Diabetes Care ___ Table ART-1/2/3: Disease Modifying Anti-Rheumatic Drug Therapy for RA ___ Table LBP-1/2: Use of Imaging Studies for Low Back Pain ___ Table AMM-1/2/3: Antidepressant Medication Management ___ Table ADD-1/2: Follow-up Care for Children Prescribed ADHD Medication ___ Table FUH-1/2/3: Follow-up After Hospitalization for Mental Illness ___ Table APC-1/2: Use of Multiple concurrent Antipsychotics in Children and Adolescents ___ Table APM-1/2: Metabolic Monitoring for Children and Adolescents on Antipsychotics ___ Table MPM-1/2/3: Annual Monitoring for Patients on Persistent Medications ___ Aspirin Use and Discussion (ASP) (2-year rolling average--CAHPS) ___ Medical Assistance with Smoking and Tobacco Use Cessation (MSC) (2-year rolling average--CAHPS) ___ Flu Vaccinations for Adults Ages 18–64 (FVA) **Access/Availability of Care:** ___ Table AAP-1/2/3: Adults' Access to Preventive/Ambulatory Health Services ___ Table CAP-1/2: Children's and Adolescents' Access to Primary Care Practitioners ___ Table IET-1/2/3: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment ___ Table PPC-1/2: Prenatal and Postpartum Care ___ Table CAT: Call Answer Timeliness ___ Table APP-1/2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics **Satisfaction with the Experience of Care:** ___ HEDIS/CAHPS 5.0H: Adult survey ___	___ HEDIS Submission Tool ___ Verification that NCQA specifications were followed: ____ HEDIS Compliance Audit, or ____ Attestation from vendor, or ___ Vendor certification from NCQA

CHECKLIST FOR MANAGED NON-MENTAL HEALTH CARE ORGANIZATIONS RULE 9-03 JULY 15TH DATA FILING		
HEDIS®	**Use of Services:** ___ Table W15-1/2/3: Well-Child Visits in the First 15 Months of Life ____ Table W34-1/2: Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life ____ Table AWC-1/2: Adolescent Well-Care Visits ____ Table FSP-1&2: Frequency of Selected Procedures ____ Table AMB-2/3: Ambulatory Care ____ Table IPU-2/3: Inpatient Utilization General Hospital/Acute Care ____ Table IAD-1/2/3: Identification of Alcohol and Other Drug Services ____ Table MPT-1/2/3: Mental Health Utilization ____ Table ABX-1/2/3: Antibiotic Utilization ____ Table PCR-2/3: Plan All-Cause Readmissions **Relative Resource Use[21]:** ___ Relative Resource Use for People with Diabetes (RDI) ___ Relative Resource Use for People with Asthma (RAS) ___ Relative Resource Use for People with Cardiovascular Conditions (RCA) ___ Relative Resource Use for People with Hypertension (RHY) ___ Relative Resource Use for People with COPD (RCO) **Health Plan Descriptive Information:** ___ Table ENP-2: Member Months of Enrollment by Age and Sex (Specify Product)	

[21] In 2011 NCQA changed the method for reporting Relative Resource Measures and required the submission of XML data through the IDSS and no longer provides a visual presentation of the data. As such the Department cannot provide Excel tables for this submission. MCOs should provide RRU data in XML format.

CHECKLIST FOR MANAGED NON-MENTAL HEALTH CARE ORGANIZATIONS RULE 9-03 JULY 15TH DATA FILING		
CAHPS® 5.0H Surveys	Plans may submit either their CAHPS banner tables or the CAHPS survey submission templates provided by the Department, so long as all required information is provided. Please check in the box to the right which option is being used to meet the CAHPS data submission requirements.	_____ certification letter from vendor _____ survey response rate summary table (hard copy) _____ CAHPS banner tables, or _____ CAHPS survey submission (using Department templates)
Provider Directory		_____ Provider Directory (Hard copy, disc or URL link)
UR Decisions	Please check the methodology used for generating the sample: ___ 60 prospective reviews, or ___ entire population of denials and then randomly sampled approvals until sample size equals 60 Verify (check) that this parameter is met: ___ reporting is in terms of calendar days UR data should be submitted for the previous 12-month period (January 1– December 31).	_____ Table 1: Time to make UR decisions from receipt of request
Access: Travel Time **Access to PCP**	Verify (check) that each parameter is met: ___ network composition is as of any time between April 1st and June 30th of year in which the report is being filed ___ travel time is reported in terms of minutes using Department-adopted assumptions regarding miles per hour ___ data is provided across entire Vermont service area Verify (check) that each parameter is met: _____ includes only panels open to new patients _____ adult PCP includes internists, family practitioners and OB/GYNs (if actively serving as PCP) _____ pediatric PCP includes pediatricians and family practitioners _____ child is defined as a member up until the 20th birthday for this purpose	_____ GeoAccess report for adult PCP within 30 minutes _____ GeoAccess report for pediatric PCP within 30 minutes
Access: Travel Time Access to outpatient MH and CD facilities	Verify (check) that each parameter is met: _____ access to MH and CD providers are reported separately	Two separate GeoAccess reports for each of the following (one representing the entire Vermont service area and one depicting access by county) **Outpatient/ED mental health by provider type within 30 minutes** **VT County** ____ ____ psychiatrist ____ ____ psychologist (doctoral level only) ____ ____ master of social work and other master's level (including all master's level psychologists) ____ ____ all outpatient MH providers (single aggregatereport of all the above categories of MH provider types) ____ ____ all ambulatory CD providers (single aggregate

CHECKLIST FOR MANAGED NON-MENTAL HEALTH CARE ORGANIZATIONS RULE 9-03 JULY 15TH DATA FILING		
		report of all the above categories of CD provider types)
Access: Travel Time Access to specialty services		Separate GeoAccess reports for access to each of the following services: **Specialty service by provider type within 60 minutes** **VT County** ____ ____ inpatient mental health, ____ ____ inpatient chemical dependency, ____ ____ intensive outpatient/partial hospitalization mental health providers ____ ___ intensive outpatient/partial hospitalization chemical dependency providers **Selected outpatient specialty care specified by the Department. For the July 2015 filing, submit access reports for the following outpatient specialties:** ____ ____ Dermatology ____ ____ Allergy ____ ____ Orthopedic Surgery **Specialty service by provider type within 90 minutes** **VT County** ____ ____kidney transplantation
Access: Waiting Time	Waiting time is assessed separately for combined mental health/substance abuse services. Please check the methodology used for assessing waiting times: _____ entire membership _____ sampled membership _____ if used a sample, verify that written description of sampling methodology was provided	Results of waiting time assessment for each of following services: (separate assessments should be provided for mental health/substance abuse and for physical health) **Phys. MH/SA** ____ ____ urgent care ____ ____ non-emergent, non-urgent care and follow-up ____ _NA_ preventive care (including routine physical exam)
Grievances	MCOs should note that there is no differentiation between physical health and mental health/substance abuse services for reporting purposes for grievances unrelated to an adverse benefit determination. Grievance data should be submitted for the previous 12-month period (January 1– December 31). Pharmacy grievances must be included in grievance reporting.	_____Table 2: Grievance frequency and outcome _____Table 3: Grievance resolution process - days to make a decision _____Table 4: Number and percent of grievances per member _____ Grievance Register Grievance register must contain: ___ unique identifying number for each grievance ___ general description of grievance ___ date grievance received by MCO ___ dates of review and hearing ___ whether grievance was resolved at first level or required second level review ___ date all necessary information was received in event of extension

CHECKLIST FOR MANAGED NON-MENTAL HEALTH CARE ORGANIZATIONS RULE 9-03 JULY 15TH DATA FILING		
		___ grievance resolution & date of resolution
Lists of Current and Terminated Providers		___ list of terminated providers[22] (by MCO action) and reason for termination
Annual Provider Satisfaction Survey		____ blank copy of provider satisfaction survey ____ results of provider satisfaction survey ____ summary of corrective actions taken based on prior year's provider satisfaction survey
Rule H-2009-03 Delegated Functions		____ Table 5: List of Delegated Functions & Entities (provide effective dates for any newly delegated functions over the past reporting period)
Coordination and Continuity of Care Indicators		_____ HEDIS® Table PCR – 2/3 Plan All-Cause Readmissions (Included in HEDIS® section)
Blueprint for Health	Data should be submitted for the previous 12-month period (January 1– December 31).	_____ Table 6: Percent of contracted PCPs receiving enhanced payment to support medical home operation _____ Table 7: PMPM value of enhanced practice payments to support medical home operation _____ Table 8: Names and the percentage of Vermont Hospital Service Areas where the MCO is making payments to support Community Health Teams in accordance with Vermont Blueprint-defined payment terms
Material Changes	MCOs are required to submit information regarding material changes to policies, procedures, member communications, provider contracts or any other documents required by this rule.	_____ Material changes submitted

[22] MCOs should only report on those providers whose contracts were terminated due to MCO action, and not those terminated due to retirement, death, those who choose to end contracts, or relocation outside of Vermont.

Checklist for MBHOs

CHECKLIST FOR MANAGED MENTAL HEALTH CARE ORGANIZATION RULE 9-03 JULY 15TH DATA FILING		
HEDIS®	____ MH Utilization - % of members receiving any services, inpatient, intensive outpatient or partial hospitalization, and outpatient or ED services	____ HEDIS Submission Tool ____ Verification that NCQA specifications were followed: ____ HEDIS® Compliance Audit, or ____ Attestation from vendor, or ____ Vendor certification from NCQA
Access: Travel Time	Verify (check) that the parameter is met: ____ access to MH and CD providers are reported separately	Two separate GeoAccess reports for each of the following (one representing the entire Vermont service area and one depicting access by county) : **Outpatient/ED mental health by provider type within 30 minutes, except as otherwise indicated:** **VT County** ____ ____ psychiatrist ____ ____ psychologist (doctoral level only) ____ ____ master social work and other masters level (including all masters level psychologists) ____ ____ all outpatient MH providers (single aggregate report of all the above categories of MH provider types) ____ ____ all ambulatory CD providers (single aggregate report of all the above categories of CD provider types) ____ ____ intensive outpatient/partial hospitalization mental health providers within 60 minutes ____ ____ intensive outpatient/partial hospitalization chemical dependency providers within 60 minutes ____ ____ inpatient mental health providers within 60 minutes ____ ____ inpatient chemical dependency providers within 60 minutes
Access: Waiting Time	Waiting time is assessed separately for combined mental health/substance abuse services. Please check the methodology used for assessing waiting times: _____ entire membership _____ sampled membership _____ if used a sample, verify that written description of sampling methodology was provided	_____ results of waiting time assessment for the following service: _____ urgent care _____ non-emergent, non-urgent care and follow-up

CHECKLIST FOR MANAGED MENTAL HEALTH CARE ORGANIZATION RULE 9-03 JULY 15TH DATA FILING		
UR Decisions	Please check the methodology used for generating the sample: ___ 60 prospective reviews, or ___ entire population of denials and then randomly sampled approvals until sample size equals 60 Verify (check) that this parameter is met: ___ reporting is in terms of calendar days UR data should be submitted for the previous 12-month period (January 1– December 31).	_____ Table 1: Time to make UR decisions from receipt of request
Grievances	Please note that grievance data should be submitted for the previous 12-month period (January 1– December 31).	_____Table 2: Grievance frequency and outcome _____Table 3: Grievance resolution process - days to make a decision _____Table 4: Number and percent of grievances per member _____ Grievance Register Grievance register must contain: ___ unique identifying number for each grievance ___ general description of grievance ___ date grievance received by MCO ___ dates of review and hearing ___ whether grievance was resolved at first level or required second level review ___ date all necessary information was received in event of extension ___ grievance resolution & date of resolution
Lists of Current and Terminated Providers		_____ Provider directory (hard copy or electronic) _____ list of terminated providers[23] (by MCO action) and reason for termination
Annual Provider Satisfaction Survey		_____ blank copy of provider satisfaction survey _____ results of provider satisfaction survey _____ summary of corrective actions taken based on prior year's provider satisfaction survey
Rule H-2009-03 Delegated Functions		_____ Table 5: List of Delegated Functions & Entities (provide effective dates for any newly delegated functions over the past reporting period)
Material Changes	MBHOs are required to submit information regarding material changes to policies, procedures, member communications, provider contracts or any other documents required by this rule.	_____ Material changes submitted

[23] MCOs should only report on those providers whose contracts were terminated due to MCO action, and not those terminated due to retirement, death, those who choose to end contracts, or relocation outside of Vermont.

Appendix B

Section 6.3(G) Performance Improvement Measures

Under Section 6.3 (G) in Rule H-2009-03, managed care organizations are responsible for measuring and reporting on provider-level performance, catalyzing quality improvement across the provider network, and motivating improvement among underperforming providers. However, since the inception of Rule H-2009-03 and a variety of health care reforms, Vermont's health care landscape has changed considerably. Most significantly, with financial support and input from the state's largest commercial health insurers, the Vermont Blueprint for Health has systematically implemented a sophisticated and evolving quality measurement and improvement infrastructure over the past six years. The Blueprint quality improvement initiatives have proven to be extremely effective mechanisms for addressing many of the elements in Part 6.3 of Rule H-2009-03 and include participation of the major managed care organizations in Vermont.

Part 6 of Rule H-2009-03 gives the Department the authority to deem managed care organizations compliant for certain review requirements, at its discretion, and currently provides deeming opportunities against the standards of independent accreditation organizations. As a result of discussions between DFR and the Blueprint, the Department has decided to deem MCOs as meeting the requirements for quality improvement goals and activities outlined in the Rule under 6.3(B)7, 6.3(B)8, 6.3(C), 6.3(D)1 and (D)2, and 6.4. This is conditioned upon MCOs continuing participation in the Blueprint for Health and meeting the following requirements:

- MCOs will continue to provide enhanced payments to NCQA-recognized practices and shared capacity payments to community health teams that participate in the Blueprint for Health; and,
- MCOs will continue to participate in statewide leadership committees (such as the Blueprint's Expansion Design and Evaluation and Analytics Work Groups, and Executive Committee) to set data-driven priorities which will fuel locally-facilitated quality improvement projects.

This new deeming opportunity should allow provider and health plan improvement activities to be consolidated through the Blueprint for Health, redundancies eliminated and administrative burdens minimized. Effective immediately, the Department will no longer require MCOs to submit annual quality improvement goals (by March 31) and annual year-end quality improvement reports will no longer be required. DFR will however monitor managed care organization involvement in these activities and the relevance of the activities to Part 6 of Rule H-2009-03 requirements by participating in the aforementioned Blueprint work groups. [All Plan Memo, *New Deeming Opportunity under Rule H-2009-03 for Quality Improvement Requirements,* October 22, 2014, by Dawn Bennett]

Appendix C

VERMONT REGULATORY REQUIREMENTS ADDENDUM

This Vermont Regulatory Requirements Addendum ("Addendum") is made part of the Provider Agreement ("Agreement") entered into between [MANAGED CARE ORGANIZATION NAME] and the health care professional or entity named in the Agreement ("Provider"). This Addendum applies to the covered services rendered to members in Vermont to the extent such covered services are subject to regulation under Vermont laws.

[MANAGED CARE ORGANIZATION NAME], and Provider each agree to be bound by the terms and conditions contained in this Addendum. In the event of a conflict or inconsistency between this Addendum and any term or condition contained in the Agreement, this Addendum shall control, except with regard to health benefit plans outside the scope of this Addendum.

1. **Member Hold Harmless.** Provider agrees that in no event, including nonpayment or insolvency of [MANAGED CARE ORGANIZATION NAME], or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or a person (other than [MANAGED CARE ORGANIZATION NAME]) acting on behalf of the member for services provided pursuant to the Agreement. This Agreement does not prohibit Provider from collecting coinsurance, deductibles or copayments, as specifically provided in the certificate of coverage, or fees for uncovered services delivered on a fee-for-service basis to members.
   This Agreement prohibits Provider from requesting payment from a member for any services that have been confirmed by independent external review obtained through the Department of Financial Regulation pursuant to Vermont law to be medically unnecessary, experimental, investigational or a medically inappropriate off-label use of a drug.
2. **Continuation of Covered Services Following Termination.** In the event of [MANAGED CARE ORGANIZATION NAME]'s insolvency or other cessation of operations, covered services to a member will continue to be provided through the period for which a premium has been paid to [MANAGED CARE ORGANIZATION NAME] on behalf of the member or until the member's discharge from an inpatient facility, whichever period is greater. Covered services to a member confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the member's continued confinement in the facility is no longer medically necessary.
   In the event the Agreement is terminated without cause, or has not been renewed without cause, members receiving an ongoing course of treatment from Provider may continue to utilize Provider so long as Provider agrees to abide by [MANAGED CARE ORGANIZATION NAME]'s payment rates, quality of care standards and protocols, and to provide the necessary clinical information to [MANAGED CARE ORGANIZATION NAME], as follows: members with disabling or degenerative conditions shall be allowed to continue to see Provider for sixty (60) days from the date of termination or nonrenewal or until accepted by a provider contracted with [MANAGED CARE ORGANIZATION NAME], whichever is shorter, and women in their second or third trimester of pregnancy shall be allowed to continue to obtain care from Provider until the completion of postpartum care.
3. The provisions in Sections 1 and 2 shall be construed in favor of the member, shall survive the termination of the Agreement regardless of the reason for termination, including [MANAGED CARE ORGANIZATION NAME]'s insolvency, and shall supersede any oral or written contrary agreement between Provider and a member or a member's representative if the contrary agreement is inconsistent with the "Member Hold Harmless" and "Continuation of Covered Services Following Termination" provisions in Sections 1 and 2.

4. **Notice of Termination.** Either party terminating the Agreement without cause shall provide to the other party advance final written notice in the form and for the length of time as provided in the Agreement but in no case less than sixty (60) days before terminating the Agreement.
5. **Notice of Termination to Members.** [MANAGED CARE ORGANIZATION NAME] shall provide written notice of the termination of Provider at least six (6) weeks prior to the anticipated date of a termination without cause, or on, or if possible, before the date on which the Agreement is terminated by [MANAGED CARE ORGANIZATION NAME] or Provider for cause, to all members <who are patients of [IF PRIMARY CARE PROVIDER]> [OR] <who are seen on a regular basis by Provider [IF SPECIALTY PROVIDER]>. Within five (5) business days of the date Provider either gives or receives notice of termination, either for or without cause, Provider shall supply [MANAGED CARE ORGANIZATION NAME] with a list of his or her patients that are members of [MANAGED CARE ORGANIZATION NAME].
6. **No Transfer of [MANAGED CARE ORGANIZATION NAME]'s Liability.** Nothing in the Agreement shall be construed to contain any clause purporting to transfer to Provider, other than a medical group, by indemnification or otherwise, any liability relating to the activities, actions or omissions of [MANAGED CARE ORGANIZATION NAME].
7. **Disclosure of Contract Provisions.** Nothing in the Agreement shall be construed as prohibiting Provider from disclosing to members or potential members information about the Agreement or the members' health benefit plans that may affect their health or any decision regarding health.
8. **Freedom to Discuss Treatment Options.** Nothing in the Agreement shall be construed as prohibiting Provider from, or penalizing Provider for, discussing treatment options with Members regardless of [MANAGED CARE ORGANIZATION NAME]'s position on the treatment options, or advocating on behalf of members within the utilization review or grievance process established by [MANAGED CARE ORGANIZATION NAME], nor shall it penalize Provider because Provider in good faith reports to state or federal authorities any act or practice by [MANAGED CARE ORGANIZATION NAME] that jeopardizes member health or welfare.
9. **No Incentive to Forego Covered Services.** Nothing in the Agreement shall be construed to offer an inducement to Provider to forego providing medically necessary services to a member or referring a member to such services.
10. **Availability and Confidentiality of Health Records.** Provider shall make health records available as required by law to the appropriate state or federal authorities involved in assessing the quality of care or investigating grievances or complaints of Members, and shall comply with the applicable state and federal laws related to confidentiality of medical or health records.
11. **Credentialing Verification Practices.** [MANAGED CARE ORGANIZATION NAME] completes initial verification of credentials before entering into the Agreement. [MANAGED CARE ORGANIZATION NAME] will also conduct periodic recredentialing of Provider's credentials at least once every three (3) years. The criteria for credentialing and recredentialing policies and procedures are available to Provider upon written request. All information obtained in the credentialing process shall be kept confidential, except that it shall be subject to review and correction of any erroneous information by Provider. Records and documents relating to Provider's credentialing verification process shall be retained by [MANAGED CARE ORGANIZATION NAME] for at least three (3) years.
    Provider shall notify [MANAGED CARE ORGANIZATION NAME] immediately of any changes that would impact Provider’s credentialing status or ongoing availability to members, including the status of Provider's license, current level of professional liability coverage, status of hospital privileges, current DEA registration certificate and specialty board certification status as applicable.

Appendix D

Rule H-2011-02, Independent External Review

A link to this rule can be found on the Department's website below:

www.dfr.vermont.gov/sites/default/files/H_2011_02_adopted_rule.pdf

Appendix E

DFR-Approved Notices of Vermont Appeal Rights

Grandfathered Individual and Group Health Plan Rights Notices			
Attachment	**Type**	**Grievance Levels in Rights Notice**	**For Use With**
A	All-in-One	1st Level Grievance, Voluntary 2nd Level Grievance and Independent External Review	Initial UR Request Determination
B	Level One	Voluntary 2nd Level Grievance and Independent External Review	1st Level Grievance Determination
C	Level Two	Independent External Review	2nd Level Grievance Determination
D	Level One – Unrelated to Denial	Voluntary 2nd Level Grievance	1st Level Grievance Determination Unrelated to Denial
E	Level Two – Unrelated to Denial	Additional Assistance	Voluntary 2nd Level Grievance

Non-Grandfathered Individual and Group Health Plan Rights Notices (Health plans that are newly effective after July 1, 2011 provide only two types of appeal processes: 1st Level Grievance and Independent External Review.)			
Attachment	**Type**	**Grievance Levels in Rights Notice**	**For Use With**
F	All-in-One	1st Level Grievance and Independent External Review (no Voluntary 2nd Level Grievance)	Initial UR Request Determination
G	Level One	Independent External Review	1st Level Grievance Determination
H	Level One – Unrelated to Denial	Additional Assistance	1st Level Grievance Determination Unrelated to Denial
I	All-in-One	1st Level Grievance, Voluntary 2nd Level Grievance and Independent External Review	Initial UR Request Determination

Rights notices are also available on the Department's website at www.dfr.vt.gov on the Health Insurance page under Insurance.

Appendix F

General UM Requirements that Apply to Pharmacy Benefit Management

- 3.1 (B) 6: Training and Inter-rater Reliability Testing
- 3.2 (A): Written Procedures for Making UR Decisions
- 3.2 (B): Timeliness of Pharmacy Benefit UR Decisions
- 3.2 (D) 2-3: Timeframe for Completion and Notification of UR Decisions

Appendix G

Measurement Methodology and Significance Testing Criteria For Annual MCO Data Filing Evaluation Report and Consumer Health Plan Report Card

I. General Rule for Department-designed HEDIS® Composite Measures Methodology:

A. When measures included in a composite have *different* denominators the harmonic mean is used to create the composite. This method mathematically adjusts "outlier" denominators and numerators to appropriately weight each component of the composite.

B. When denominators for the composites for each of the MCOs are *identical* an arithmetic mean is used to create the composite. The arithmetic mean of the numerator is divided by the denominator, used across the measures to calculate the composite rate.

The harmonic mean test is the preferred approach when denominators are different because it is the method that most appropriately weights the denominators to obtain the most accurate significance reading. The arithmetic mean is used only in cases where the denominators are the same because using the harmonic mean in that instance results in nonsensical results.

Examples of the two approaches are shown below. The harmonic mean is calculated as the number of variables divided by the sum of the reciprocals of the variables. Consider the following examples:

Four numbers represent four numerators: 100, 110, 90, and 120

The harmonic mean of these numbers is:
4/((1/100) + (1/110) + (1/90) + (1/120)) = 103.8

As a point of comparison, the arithmetic mean of these four numbers is:
(100 + 110 + 90 + 120)/4 = 105

The resulting numerators and denominators are then used to conduct a statistical comparison of the composite rate to composite national and regional averages. Regardless of the methodology used to calculate composites, the national and regional averages for any Department-derived composite measures are created by taking the arithmetic mean of the national or regional rates.

II. Two Exception to Measure Composites:

When creating a composite using only two (2) measures where the denominators are significantly different and the rates are significantly different (i.e., more than 20 points apart), using the harmonic mean results in a nonsensical average. The Department evaluates each two-measure composite on a case-by-case basis, considering the following options:

A. Limit two-measure composites to situations where the same sample is being evaluated with related questions. An example is the CAHPS® claims payment composite, which is composed of survey answers from respondents regarding timely and correct claims payment.

B. If it is necessary to create a two-measure composite of unrelated measures (such as, care for children and colorectal cancer screening), the methodology is to average the rates and sum the denominators to run the statistical significance tests. The justification for this approach is as follows:

1. The two measures are of equal importance to the populations to which they apply, so an average of the rates weighs each measure equally.
2. Summing the denominators creates a large sample size, which increases the power of p-test.
3. The composites for the national and regional averages are created by averaging the rates.

III: Significance Testing:

Each year NCQA publishes Quality Compass, detailing national (National All Lines of Business) and regional average (New England All Lines of Business) scores for each HEDIS measure, including each CAHPS® question and composite (with the exception of first year measures). For plan types HMO, POS and HMO/POS, HEDIS® and CAHPS® measures and composites are compared to the national and regional (New England) HMO, POS and HMO/POS averages without PPO scores. For PPO plan types, HEDIS® and CAHPS® measures and composites are compared to the national and regional (New England) PPO averages.

Using the list of measures previously identified, two types of tests listed below are performed to determine whether the MCO's performance is significantly higher or lower than the national average for the measure:

1. Statistical significance, and
2. "Practical" significance.

Both of these tests are applied to point-in-time data, but no practical significance test is applied to the over-time data.

Statistical significance assesses: 1) whether there is a difference between the MCO's rate and the national and regional averages that, with a high degree of certainty (95%), is not attributable to random variation (point-in-time data), and 2) whether there is a difference between the MCO's current rate and the MCO's rate in the base year that, with a high degree of certainty (95%), is not attributable to random variation (over-time data).

Practical significance assesses whether a medical professional or a layperson would find an observed difference to be meaningful. Over the past four years, the Department employed a practical significance test of four percentage points. That is, the difference between the MCO's rate and the national rate had to be at least four percentage points (i.e., difference between 4.59% and 8.19% is 3.60 percentage points, and therefore, does not meet the practical significance test) to be scored as different in the Consumer Guide. As noted above, no practical significance test is applied to the over-time data.

The practical significance test is applied after the statistical significance test, and only in those cases in which an MCO's performance in a particular measure has been found to be statistically different from the NCQA national average. Therefore, an MCO's performance must be judged both practically and statistically significantly different from the national average to be scored as different (i.e., higher or lower) than the national or regional average within the Consumer Guide.

Starting in 2014, statistical significance and practical significance testing will be performed only when the current reporting year has a **sample great than or equal to one hundred**. Prior years used a threshold of thirty for both public reporting and statistical/practical testing. In 2014, measures with a sample greater than thirty but less than one hundred will have publicly reported rates but no statistical/practical testing. The change in methodology is to increase confidence when reporting that no statistically significant different is found when Plan rates are compared to the national and regional benchmarks or over time. This concept is referred to as "statistical power" and is defined as the probability to correctly reject the null hypothesis when the null hypothesis is false.[24] That is to say, the probability to detect a difference when there truly is a difference. When sample sizes are small, the probability of finding statistically significant differences decreases resulting in a public reporting of "no significant difference." See sample chart below.

Summary of Rate and Statistical Reporting

Sample	Rate	Statistical/Practical Significance
<30	NO	NO
<100	YES	NO
≥100	YES	YES

[24] Cohen, J. (2013). *Statistical power analysis for the behavioral sciences*. Routledge Academic.

Appendix H

Data Collection Requirements for HEDIS® Hydrid Measures

The Department wants to ensure that all HEDIS® measures are submitted using the collection methodology that allows for the best comparability across MCOs and in relation to established HEDIS® benchmarks. In a variety of instances, MCOs have not reported measures data using hybrid (record review) data where specified. This has produced inconsistent data, which has limited the Department's ability to analyze and report meaningful comparative measures.

MCOs have raised concerns about the additional costs they incur to collect record-level data for hybrid measures, and whether there is any added value to collecting hybrid-specified measures that are not also required by NCQA as "scored measures" in its annual publication, *Standards and Guidelines for the Accreditation of Health Plans*. MCOs have maintained that they should be required to provide hybrid-collected HEDIS® data for Rule 9-03 to the same extent that they provide hybrid-collected data to NCQA for accreditation, particularly since the numbers of HEDIS® measures have been increasing over time. A review of the 2014 "scored measures" list shows that the majority of hybrid-specified HEDIS® measures are included.

In consideration of these issues the Department has determined that beginning with the July 2014 data filing, the submission of HEDIS® hybrid-specified measures for Rule 9-03 will be consistent with the HEDIS® hybrid-specified measures included on NCQA's "scored measures" list for the relevant reporting year. MCOs, regardless of accreditation status, will be required to submit data for its managed health plan products (HMO, PPO, POS, EPO, etc.) using the hybrid method for any "scored" HEDIS® hybrid-specified measure. All other annual data filing requirements for HEDIS® measures under Rule 9-03 remain in effect. The Department will continue to publish all annual data filing requirements, including HEDIS® measures, in its Rule 9-03 Implementation Manual, which will track to the annual publication of *NCQA HEDIS® Volume 2: Technical Specifications.* We will also identify which measures require hybrid-specified data collection from NCQA's "scored measures" list. [All Plan Memo, *Annual Data Filing Requirements for HEDIS® Hybrid-Specified Measures,* April 22, 2013, by Dawn Bennett**]**